State of Maryland / Department of Health and Mental Hygien 04501 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 02 Year 8:40 AM **Physician** HUNTER SHARON 2009 15 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ARUNDEL ANNAPOLIS ANNE ANNE ARINDEL MEDICAL CENTER 8. Date of Birth (Month, Day, Yeer 06/25/1954 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. 1 ☐ M 2 🖺 F Months Days Hours 145-48-3080 Director New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be motified at 1 X Yes 2 No Directo MD Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1209 Hillcrest Road 21113 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Iten any injury or other traumetic event, the Medical Examines. Once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ruth Elsie Darby Thomas Clarence Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ahsikla Phylish Robinson/Daughter 2431 Clifton St., NW, Roanoke, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Ardent Cremation Services 02/17/2009 Hanover, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of uneral Service Licensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 YEAR METASTATIC PANCREAS CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death After 5 Pending 1 Natural nours after death.

neral Director: Af

filled in by the fur 1 🗌 Yes 2 🗆 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide a Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D66753 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway, Annapolis MD 21401 Capstack mo, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 04502 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2307 PM 02 2009 SONATHANI 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Franklin Sa Hospita Rosedale Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 3 MARCH 20,1925 NORTH CARDLINA 238-28-7961 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No BALTIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number AVENUE 21206 1301 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TABOR CITY TEACHER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TELFAIR HOUSE HATTIE ALONIZO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TOVONDIA FRANKLIN GOUGHTEN 5249 LAKE EDGE DRINHOLLY SPRINGS, NC 27540 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State ARRISON FOREST CEM. 09/04/2009 CWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility
TCSEPH H. BROWN JR. FUNERAL HUME 21. Signatur of Funeral Service Licensee 2140 N. FULTON AVE, BALTIMORE, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause Final disease or conclion resulting in death) 1 hour Myocardia Due to (or a a consequence of):

/Medical Examiner Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exo. it are must be multiful at once.

and Mental Hygiene.

Physician

altimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State

William andrew Reme,

31. Date filed (Month, Day, Year)

William Andrew Renie MD, 98
filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Milliam Andrew Renie, MD, 9000 Franklin

	Eagueritially list conditions,	. Heart	Disease				20 years
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):				
	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):				-10
3		.d	<del></del>	*			
yalolarimo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Ectopie	c pregnancy (specify)		23d. Date of d Month	elivery Day Year
	Part II. Other significant conditions co	ontributing to death but not resu	ilting in the underlying	g cause given in Part I.		<b>\</b>	to the cause of death? Probably 4 ☐ Unknown
					24a. Was an autopsy performe	prior to d <sub>2</sub> ? death?	autopsy findings available completion of cause of es 2 \square.
6	25. Was case referred to medical			26. Place of De	ath (Check only one)		
2	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatient 2 🗹	ER/Outpatient 3	DCA Other: 4 \( \text{Nursing} \)	Home 5 ☐ Residence	ce 6 □Other (Sp	pecify)
arloll.	27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	4
21112	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	et and Number or i State)	Rural Route Number,
alical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my kno- niner: On the basis of examina and manner stated.	wledge, death occurr tion and/or investigat	ed at the time, date and plaction, in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	29b. Signature and title of certifier			29c. License number	29d	. Date signed (Mo	nth, Day, Year)

DHMH 17 Rev 1/2001

Registrar

02-13-2009

Square Drive, Baltimore MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01289 State of Maryland / Department of Health and Mental Hygiene 04503 2009 Molly Catherine Hynes Certificate of Death 1- For State Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day February 13, 2009 Physician/ 0040 hrs Catherine Hynes Medical Examiner Molly c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number N/A **Baltimore City** 210 East Centre Street 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex oreian **Funeral** Months Days Hours JUN 6 1972 Country) MD 36 Yrs Director 2 **X** F 217-88-1166 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 No Baltimore N/A 23a or 28a-f show notified at once. MD 10g. Citizen of What Country? with the Maryland Director 10f. Zip Code 10e. Street and Number USA 21202 9 E. Read Street, Apt. 14. Race - American Indian, Black, 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) must be Armed Forces death 1 X Never Married 2 Married Yes Specify: White or Yes 2 X No specify: If Yes Give Year Divorced Widowed Examiner 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT-use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Graphic Designer marked other than 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Jane Geiger Michael J. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 1803 Kipling Drive, Salisbury, MD If item 27 is Mary Jane Hynes - mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Baltimore, Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. |02/14/2009 Baltimore, MD mportant: Donation 5 <sup>2</sup>Cremations Society of Maryland, Inc. 21. Signature of Funeral Service Licensee H. Williams 299 Frederick Road, Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Alcohol and methadone intoxication complicated by Death 'Medical Immediate Cause (Final disease aminer hyperthermia Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed 23a,2/,28a-i, perME, g889 3/3/09 Physician/Medical AMENDED tending physician a X UNPENDED 23d. Date of delivery 68760 23c. If yes, outcome of pregnancy IF FEMALE: Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Box 1 Yes 2 No 9 V Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Yes 2 No 3 Probably 4 V Unknown Ą 24b. Were autopsy findings available Completed Division of Vital Records, 24a, Was an prior to completion of cause of After this certificate has been funeral director, page 2 should autopsy performed? death? 1 V Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medica To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certifi completely filled in by the funeral director, Other<sub>4</sub> Be Residence 6 V Other; Scene examiner? Hospital: 1 Nursing Home 5 DOA ER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death unk Yes 2 X No Natural Pending Fd 12:30 Fd 2/13/09 28f. Location (Street and Number or Rural Route Number, City or Town, State) 210~E . Centre St BAltimore, MD Investigation 2 28e. Place of Injury - At home, farm, street, factory, office building, etc Accident 6 X Could not be 3 Suicide (Specify) Fd: in steam room determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 13, 2009 O.C.M.E.

Hopen

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year)

as for

**ORIGINAL** 

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OCME

Rhonda Harless	State of Maryland / Department of 1-For State Certificate of Registrar	_	/giene Reg. No.	2009 0450
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day	3. Time of Death Year 1935 hrs
•	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		ty of Death
Formul	Johns Hopkins Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year   If Under 24Hrs.		N/A
Funeral Director	219–94–4900 1 M 2 X F 37 Yrs	Months Days Hours Min.	APR 24 197	Eoroian
. áue	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits
<b>*</b> .	MD N/A Baltimo			1 X Yes 2 No
the Maryland a or 28a-f show tified at once.  Director	10e. Street and Number 104 N. Glover Street	10f. Zip Code 21224		What Country?
r death with the Maryland or items 23a or 28a-f sho must be notified at once Funeral Director	1 Never Married 2 Married Armed Forces? If Y	s Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto		ace - American Indian, Black, hite, etc.
Y Fer	or Dates:	Yes 2X No specify: t's Usual Occupation (Give kind of w		y: White Business/Industry
11215-0036  Re filed within 72 hours after death with the Maryland Acutal Hygiene.  Barked other than "natural", or items 23a or 28a-f she event, the Medical Exactive must be notified at once o Be Completed by Funeral Director		ost of working life. DO NOT use retir	ed)	tory
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mostal Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Frederick R. Rietschy	Viviar		,
MD 21 MD 21 Md should lith and Me m 27 is man aumatic ev		ys End Court,		
lore, land trof Heal	1 Burial 2 Y Cremation 3 Removal from State crematory or oti	ition (Name of cemetery, ner place) atory, Inc. 02/1		on - City or Town, State
Baltimore, permit. Pages I ar Department of Nec Important: If ite	21. Signature of Funeral Service Licensee H. Williams	enation society	of Maryland,	more, MD
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	9 Frederick Road ne mode of dying, such as cardiac or	, Baltimore, respiratory arrest, shock, or	MD 21228 heart Approximate Interval Between Onset and
/Medical caminer	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxication Due to (or as a consequence of):	on		Death
ner	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):		***	
red nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
50, ce be execute by sician and burial - tran	X UNPENDED AMENDED 23a,27,28a-f,	perMe, G389 3.26.	.09 TT	
18760 rtificate bing physical as the bunary Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	tal death 3 Ectopic pregnar		of delivery  Day  Year
D. Box 6876 the death certificate by the attending phyched for use as the Physician/M	. Pregnant at time of death	ner (Specify)		-
P.C es that gned   pe deta	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use co	ntribute to the cause of death?  3 Probably 4 Unknown
Vital Records, hysician: The law require. this certificate has been significater, page 2 should be on Be Completed			autopsy	o. Were autopsy findings available prior to completion of cause of
tal Rec		· · · · · · · · · · · · · · · · · · ·	performed?  1 Yes 2 No	death? 1 Yes 2 No
Vital ysician his cert director	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 ✓ Inpatient 2 ER/Outpatient	26.Place of Death (Check of Other And Nursing	Home 5 Residence 6	Other:
n of Vi ing Physi After this uneral din	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of In		28d. Describe how injury occ	
sion trendi death. ctor: y the fi	Pending Fd 2/6/09 Fd 1:50		unk	
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 4 Homicide  6 X Could not be determined  Could not be determined  (Specify)  28e. Place of Injury - At home, farm, street house		or Town, State)	nber or Rural Route Number, City  Ave Baltimore, II
Division To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigate	red at the time, date and place, and	due to the cause(s) and mani	ner as stated.
Mec G To Kit; To	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date si	gned (Month, Day, Year)
20,7	Monsorta me Virue	O.C.M.E.	February	7, 2009
Jan 1	<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Margarita Korell MD. Assistant Medical Examiner 111 Person 11</li></ol>	enn Street, Baltimore, MD 2	1201	
State	31. Date filed (Month Pau Year) = - 32. Register's Stonature			
Registrar	CERTYONG PROMA A. A.	barks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** February 15, 2009  $P^M$ 4:55 Wendell Everett Harsh, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson <u>Gilchrist Hospice Center</u> 8. Date of Birth (Month, Day, Year March 17, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours **1**√2 M 2 □ F Maryland 55 **Director** 212-60-6617 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ?7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Even, that must be a veilled at Director Baltimore Baltimore 1 ∐Yes 27∑ No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21206 United States 7402 Beech Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi. Department of Health and Mental Hygien. Important: If item 27 is marked other tha any injury or other traumatin..... Caplan Brothers Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Lee Bales Wendell Everett Harsh, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7402 Beech Avenue, Baltimore, Maryland 21206 Ruth Ann Harsh - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Feb. 18,2009 Forest Hill, Maryland Cremation Syrs.—Pelair 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Parkville 21. Signature of Funeral Service Licenses Stacle 8800 Harford Road, Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** exis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown icate has been si page 2 should b 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1 □Yes 2 🗷 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔲 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ne Hospital or Attendi n 24 hours after death, ne Funeral Director; 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the within 2 29b. Signature and title of certified our 

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

-32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 1250 Month Year **Physician** 200 bruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age on yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F 9 Mary Director Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examiner must be in utilised at 1 Yes 2 □ No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∭Yes 2 ☐ No If #es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ 4 ☐ Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) nameer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be one 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) te permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is any injury or other tra Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 ⊠ Burial 2 ☐ Cremation 12009 118 4 Donation 5 Dother (Specify) Vings 22. Name and Address of Facility 21. Signature of Funeral Service Licensee , P.A Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between shock or heart fail Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical cardiovascular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) P.O. I 2 🗆 No the 1 TYes 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 2 10 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day, Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Acciden 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of de a 424 W. Belvedere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician ам 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Mays Chapel Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb 14, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕱 F 228-24-0604 94 1914 Tennessee Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Bedwell Court 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Iltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( 0scar Brown Lillie McClaren ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bedwell Court Timonium, Md. 21093 Mrs. Linda Bobb/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 2-13-09 Towson, Md. 21. Signature of Funeral Service Licenses Towson Funeral Home, York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Physician Morau /Medical Due to (or as a conseque certi): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 9□Unknown 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Marmer of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Detritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

and

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

09-01279 Daniel Hoeck

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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niel Hoeck		State of Maryland / Department of Hea	nth Reg. No.
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year February 12, 2009  3. Time of Death 1235 hrs
edical Exami		Daniel Lee Hoeck	February 12, 2009  7, Town, or Location of Death  4c. County of Death
		4a. Facility Name (in not institution, give street	timore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur	nder 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		214-46-7620   1 <sub>X</sub> M 2 F   62 Yrs.   Mor	hths Days Hours Min. October 01, 1946 Country) Maryland
	t	Usual Residence of Decedent	10d. Inside City Limits
w any		Tod. State	1 X Yes 2 No
Maryland 28a-f show any d at once	횽	Maryland Baltimore  10e Street and Number 10f.	Zip Code 10g. Citizen of What Country?
e Mar or 28s	Director	6116 Glenoak Avenue	21214 U.S.A.
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mannell Hygiens of Maryland int. If item 27 is marked other than "matural", or items 23a or 28a-f sho int. If item 27 is marked other than "matural", or items 23a or 28a-f sho		If Voc on	edent of Hispanic Origin? (Specify Yes or No- ecify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
death or item	Funeral	1 X Never Married 2 Married 1 X Yes 2 No	
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136 thin 72 hours afte te. than "uatural", edical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completes)  Elementary/Secondary (0-12)  College (1-4 or 5+)	working life. DO NOT use retired)
5-0036 ed within 72 tygiene. other than '	l du		e Engineer Computer
5-0036 Tled within 77 Hygiene. d other than	ပ္ပ	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Malden Surname)
2121: uld be fil Mental I marked	a	Henry Joseph Hoeck, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addi	Elizabeth McDonnell ress (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 21215-003 nd 2 should be filed within thth and Mental Hygiene. m 27 is marked other th	ြို	Tod: Milotina Comment	
ore, MEss 1 and 2 soft Health as 1 freem 27 her traums		20a. Method of Disposition	
ages 1 nt of F		1 Burial 2 X Cremation 3 Removal from State Hilltop Serv	vice Corp. 2-16-09 Towson, Maryland
Baltimore, ME permit Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Funeral Service Lick s	and Address of Facility Ruck Towson Funeral Home, Inc.
in jer ထ	<u>L</u>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo	O York Road, Towson, Maryland 21204
Physician 'M. dical		failure. List only one cause on each line.	Between Onset and Death
amine		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
		Sequentially list conditions, b.	
	Je.		
	Examine	C. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
50, te be executed yysician and burial - transit	<u>@</u>		
50, te be exe ysician a	edical	UNPENDED AMENDED	23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Division: After for a Hospital in the control of the former of th	8	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal d	Marth Day Year
Box 6876 death certificate the attending phy of for use as the	Physician/M	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)
Boy e death the att	hvs	1 Yes 2 No 9 Unknown 9 Unknown	riving cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.			1 Yes 2 ✔ No 3 Probably 4 Unknown
S, P quires 1 en sign			24a. Was an autopsy findings availat prior to completion of cause o
cords, law requir has been s	¹   7		autopsy prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rection: The certificate	, page		26.Place of Death (Check only one)
ital	or the functar unector, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursing Home 5 Residence 6 ✔ Other Scene
of Viring Physical After this	T L	27 Manner of Death 28a, Date of Injury 28b, Time of Injur	y 28c. Injury at Work? 28d. Describe how injury occurred Subject assaulted
OD (canding sath or: A	i i	27. Manner of Death  1 Natural 5 Pending FoUND:  Accident Investigation Peb 12, 2009 1222 hrs	1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requir its after that all Unrestor. After this certificate has been in all Unrestor. After this certificate annual checkels.	6 L	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f.	actory, office building, etc.  28f. Location (Street and Number or Rural Route Number, C or Town, State) 6116 Glen Oak Avenue, Baltimore, MD
Di Hospital 24 hours a Funeral I	Tilled in of the tune	4 V Homicide determined (Specify) Single Family	
To the Hospital within 24 hours			at the time, date and place, and due to the cause(s) and manner as stated.  In my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the	com	(Check only one)  2   Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	"	Ou or	O.C.M.E. February 13, 2009
		30. Name and address of person who completed cause of death (Item 23a)	
241	/	Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201
V	Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	9
Red	jistr	31 LED - 1 7000 \	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1/ per fh g888 2-24-09 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04509 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day FEBRUARY 13 **Physician** 2009 01:54 AM Essie Holmes Hurt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 🛠 🗆 F 04 Director 220-22-9821 21 91 VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exactions must be redified at YE Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2913 Fendall Road 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 2 Specify: 3√2 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade na Seamstress Clothing Factory marked other 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Jennings <del>Jenkins</del> Annie Clark ٩ James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Health a 3805 North Rogers Ave, Baltimore, Md 21207 William A. Baker-Son timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 2/21/2009 Baltimore Co, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service nom psin 21215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or se a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Year Day 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat.

Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 15-44728 | Z-13-2009 6535N.CinylesSt. Tousin, Mp 2/204

State Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

ause of death (14 m 23a) (Type, Print)

92. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Margaret Hughes 9:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Franklin Square
5. Social Security Number 6. Se ta1 Center ROSEDICIE If Under 1 Year If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2**X** F Months Days Hours Min. 99 Director 220-12-2958 MD 1/24/1910 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If e Invition Examples in other and once. Director Yes 2□No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2429 Knapps Way 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn M. Munk / Granddaughter 2429 Knapps Way, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ardent Crematory 02/13/2009 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 22. Name and Address of Facility
Maryland Cremation Services Signature of Funeral Service Licensee Dorota Marshall 1840M PO Box 1413, Baltimore, MD21203-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, (shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 🤜 Physician HI 2 day. disease or condition resulting in death) /Medical Due to (or is a consequence of): Examiner umera if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given 🖟 🚧 t I. 23e. Did tobacco use contribute to the cause of death? é cate has been sl 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? promboc 24a. Was an autopsy performed? After this certificate Dementia 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 des 2 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Patient fell walking down hallway with Walker 1 Natural 5 Pending investigation 10:47PM within 24 hours are control to the Funeral Director: Al 1 □ Yes 2 교 No 109 2 Accident /10 3 Sulcide 6 Could not be 28e. Place I Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hall NUCSing 1300 WindLass tre MiddleRivee me the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) quse of death (Item 23a) (Type, Print) 30. Name and address of person who completed 31. Date filed (Month, Day, Year) State 32. Redistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** PM Mary E. Harcum FEBRUARY 145 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT AGNES HOSPIT A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Months Days Hours 213-28-7914 78 Director 03-07-1930 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show N/A 1X Yes 2 □ No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 2520 Lauretta Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: Specify. Specify: African American þ 3 ☐ Widowed 4 💆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien important: If Item 27 is marked other the lany injury or other traumatic event, Item once. Factory Worker Carr Lowrey Glass Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Peters Evelyn Crawford ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Harcum 2825 Presbury Street Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill 02-20-2009 Glen Burie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 538 N. Gilmor Street Baltimore, MD 21217 DONE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NTRACRAMIAL Horas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) □Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy certificate 1 □ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1∐ Yes 2⊠ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No i Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64307 13. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON A VITBERF AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For State Registrar	State o	f Marylan		artmen rtificat			and M	/lental Hy	giene Reg. No	200	9	045	12
Physicia	an	1. Decedent's Name (First, Middle		+ho140	U : 1 1					2. Date of De Month	Day	3000°	ar	3. Time of	Death A M
/Medic	al	4a. Facility Name (If not institution		thalie	H <b>ill</b>	4b. City.	Town, or	Location of	of Death	Februai		2009 County of D	eath	5:17	A W
Examin	er	Suburban Hosp	_				ethe					ntgom			
Funeral Director		5. Social Security Number 556-50-3544	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 73	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da August	th Year) 4, 19:	9. Ca	Birthpla Countr 1111	ornia	r Foreign
e Maryland 8a-f show	Director	,	omery	10c. Cit	y, Town or Lo	omac								d. Inside Cit	
with th	Dir	10e. Street and Number 8503 Timber H	H11 Lane			10f. Zip	Code 20854					en of What :ed St			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 💆 Man 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For ried 1 \( \text{Yes} \) Gi	2∭ No ve			ent of His	spanic Ori n, Mexicar Specify:		pecify Yes or No Rican, etc.)	)- 1	4. Race - A Black, W Specify:	mericar	n Indian,	
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uld be filed Mental Hyg Irked other tic event,	To Be C	17. Father's Name (First, Middle,  John Whitehea								e (First, Middle Elizab		,			
and 2 shores alth and I and I and I see trauma		19a. Informant's Name/Relations Jacques Hill /			8503	Timbe	r Hi	11 La		Potoma	c, Ma	rylan	d 2	0854	
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permit. Departi Importi any inj		21. Signature of Funeral Service	Licensee /	M0130	∖∈  Ro	2. Name an bert A 57 Wise	. Pum	phrey	Fune	ral Home/ Bethesda.	Bethe: Maryl	sda-Che and 208	vy C 314–3	hase, 3501	Inc.
Physician /Medical		23a. Prrt1. Leter the disease, or neart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	caused the deat each line. astatic (or as a conseq	Non-Si						rrest,		1 1	Approximate nterval Bety Onset and D	veen
Examiner	er	Sequentially list conditions,	b	or as a conseq									-		
te be executed ysician and e burial-transit	Jical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live	tcome of pregna birth 2  Feta nant at time of a	al death 3	☐ Ectopic p ☐ Other (sp					2	3d. Date of Month		-	'ear
quires that in signed build be deta	ρ	Part II. Other significant conditi	ons contributing to d	eath but not res	ulting in the u	nderlying c	ause give	n in Part I			tobacco us Yes 2 [	**		cause of d	
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al or Atter s after dea il Director ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ainod 200, Place	e of Injury - At h ing, etc. (Speci	ome, farm, sti fy)	reet, factory	, office			28f. Location ( City or To	Street and wn, State)	Number o	r Rural i	Route Num	ber,
ne Hospit n 24 hour ne Funera	Medical C		ng Physician: To the Examiner: On the b and man												)
To within comp	Me	29b. Signature and title of certific	, ·				C. License		6			signed (M	onth, D	ay, Year)	
		30. Name and address of person Yuneng Oswald 1		se of death (Ite		Print)				da. Mar	vlan	1 208	 L 4		
Sta Registr		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	arked		,			J				

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5 Per FH C888 2/19/09 IIII
State of Maryland/Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 12 2009 2:45 p M Irvin Beatrice L. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Catonsville Baltimore 157 Sanford Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG 16 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2 1 □ F 87 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Catonsville 1 Yes 2K No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21228 USA 157 Sanford Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry
Social Security 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Benefit Authorizer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hanel UNK Albert Lorenz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 157 Sanford Avenue, Catonsville, MD 21228 Maurice Irvin - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc.02/13/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Strevense H. Williams Tremation Society of Maryland, Inc. Will. 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cegnin thy disease or condition resulting in death) Due to (or as a consequence of): Obstantine Pulmong Distine Chronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Wyser Know 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Pontul small Bred 1 □Yes 2 No 1 ☐ Yes 2/2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide

Examiner law requires that the death certificate be executed physician and the burial-tran Box 68760. attending pl signed by the a P.0. Division of Vital Records, icate has been siç , page 2 should b Hospital or Attending Physician: The funeral director. this After death. after death Director:

Examine Physician/Medical Completed by Be Certification: To

1 24 hours after le Funeral Dire pletely filled in b

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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7 is marked other than "natural", or items traumatic event, the Medical Examiner or 1 and 2 should be filed within 72 hours after Health and Mental Hygiene.

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Physician

/Medical

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Baltimore, Maryland 21215-0036

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Director

Funeral

Be Completed by

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25. Was case referred to medical examiner?

29b. Signature and title of certifier

4 ☐ Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number 034957

29d. Date signed (Month, Day, Year) 2809

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suck 100 Colombille us 2,220 (1600 m/2 31. Date filed (Month, Day, Year)

Registrar

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completely

within 2

Medical

29a. Certifier

(Check only

32, Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per Phy G888 2/17/09 Jh
State of Maryland / Department of Health and Mental Hygiene amend 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** I llery 2009 DWARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 71 mewood Balhanne CIEMESIS N/A 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 ☐ F Director 249-46-8136 Usual Residence of Deceder 07 SC 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □ Yes 2 □ No Funeral Director NA MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature" any injury or other traumatic...... 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 2865 Edgecomb Cir South Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Molder Abex Corp. 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Illery Winnie Illerv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) Mazie Illery-Wife 2865 Edgecomb Cir South, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 2/11/09 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Regulator failure disease or condition resulting in death) / week /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying bases that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 after death.

I Director: After this certificate has been signated the second of the s Seizures 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed multiple cuists 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/5/49 Klu D31291 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 1206 5701 Kemwood 10/0012 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sarked Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 8889 3-18-09 yr State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 5:25 P.M 2009 ETTA MELTON JOHNSON February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 NC 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Hours Min Months Yrs. JUNE 8, <del>1918</del> Director 92 230.18.6288 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it we Medical Examiner must be notified at 1 Yes 2 No Director WASHINGTON **HAGERSTOWN** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20014 ROSEBANK WAY, STE. 321 21742 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2XX No Specify: 2 Specify: 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 DIETICIAN PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER MELTON ပ္ ETTA BROKE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN BRYANT DAUGHTER 18534 INDIAN COTTAGE RD. HAGERSTOWN, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation XX Removal from State GREENLAWN MEMORIAL CARDENS 2.7.2009 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE, VA Punital Pytyle Liv FINK FUNERAL HOME, P.A. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest principles. Do not enter the mode of dying, such as cardiac or respiratory arrest principles. 23a. Part 1. shock Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) **Physician** DAY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed | d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ficate has been si r, page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate **Division of Vital** 1 □Yes 2 No 1 ☐ Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number no completed cause of death (Item 23a) (Type, Print) Mame rson HUNWITZ 110 Medical Campus Rd. Hage strun; MD 62. Registrar's Signature 31. Date filed (Month, Day, 21147 State Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 04516 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Geffcken Margaret Jenkins 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 93 226-22-0687 Director 02/15/1915 GA Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar mast be notified at Director MD 1 Yes 2 □ No Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7956 Vanity Fair Drive 20770 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify. Specify ICNKINS, Margarer 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace E. Geffcken Nancy Beal1 ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Robert Jenkins Jr. / Son 7956 Vanity Fair Drive, Greenbelt, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 K Removal from State 2/21/2009 Olive Branch Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Portsmouth, VA 21. Signature of Euneral Service Licensee Dorota Marshall 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** espirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Examine signed by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ **(**)o 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s perform 2 100 1 ☐ Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1∐ Yes 2 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation spital or Attendi nours after death. neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D Hospital of the Hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certified MDD 60611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SFAW M 32. Register's Signature 8118 GOOD LOCK ROAD LAWHAM, ND 20701

			for State Registrar	State o	of Marylan	id / Depa <i>Cei</i>	artment ( <i>rtificate</i>	of He of De	alth ai <i>eath</i>	nd Me		giene 2 Reg. No.	00	9 0451
			1. Decedent's Name (First, Midd	e, Last)						2	. Date of De	ath		3. Time of Death
	Physici /Medio		Eunice Kathe	rine Jone	S						Month 2/15	/2009	Year	8:00 P M
The same of	Examir		4a. Facility Name (If not institution				4b. City, Tox	wn, or Lo	ocation of	Death			inty of Dea	
1			Chapel Hill	Nursing H	ome		Rano	dal1	stown	n		Ва	ltimo	ore
	Funeral	Г	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		f Under 24		Date of Bir	th Year)	9. Bii	rthplace (State or Foreign
	Director		215-42-6410	1 □ M 2 <b>K</b> F	92	Yrs.	Months D	Days	Hours	Min.	(Month, Da 9/11/	1916		MD
3	2 .		Usual Residence of Decedent											
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1	illed within 72 hours after death with the Maryland Hygiene. Hygiene han "natural", or items 23a or 28a-f show ent, the Masilcal Examiner must be notified at	Funeral Director	5700 Lakeside	Drive			2178	84				USA		
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lar j	~ m m =		19a. Informant's Name/Relations				ig Address (S					-		
	1 27 # S		Martin L. Jo	nes/Son					losso					L 34465
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Δ :	any any once		Jane 1	3 Caul	W									MD_21784
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<b>6</b>	atte	ciar	in the past 12 months?	1 ☐ Live	birth 2 🗍 Feta nant at time of c	Ideath 3	Ectopic preg Other (speci						Month	Day Year
o §	the ched	ysi	1 ☐ Yes	9 ☐ Unki		Jean. 0 L	Journel (Speed	119/						
<b>o</b> . ‡	ned by the detached		Part II. Other significant conditi	ons contributing to d	leath but not resi	ulting in the ur	nderiving caus	se given i	in Part I.		23e. Did to	obacco use c	ontribute t	to the cause of death?
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		Ë	27. Manner of Death 1 ♣ Natural 5 □ Pendir	28a. Date	of Injury oth, Day, Year)	28b. Time of Injury	28c.	Injury at Work?	t	280	d. Describe I	now injury occ	curred	
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Division	after death	ļį į	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ingd 28e. Place	e of Injury - At ho ling, etc. (Specif	ome, farm, stre	eet, factory, of	ffice		281	Location (S City or Tox	Street and Nu	mber or R	lural Route Number,
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Hoenital	within 24 hours after To the Funeral Directory completely filled in b	Medical	29a. Certifier T Certifyii (Check only one)	ng Physician: To the Examiner: On the b	pasis of examina	wledge, death ation and/or in	n occurred at t vestigation, in	the time, my opini	, date and nion, death	place, an occurred	d due to the at the time,	cause(s) and date and plac	I manner a	as stated. e to the cause(s)
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1	0 1		30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type,		5}~	Ro	ate	oten.	Mo	711	136
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	Registr		ccp 17	onno A	read to	1. Spa	Mark							

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			For State State Registrar	or Maryland		tificate of D		Rei	g. No. 2009	9 04518
			Decedent's Name (First, Middle, Last)					Date of Death     Month		3. Time of Death
	Physicia /Medic			ny F. John	son			February		
	Examin	er	4a. Facility Name (If not institution, give street and			4b. City, Town, or L			4c. County of De	
*	Funeral		Montgomery Genera.  5. Social Security Number 6. Sex	7. Age (In yrs. la			01ney If Under 24 Hrs.	8. Date of Birth (Month, Day,	Mon	tgomery irthplace (State or Foreign
	Director		026-14-7303 1□M 2X	F 83	Yrs.	Months Days	Hours Min.	May 21,		Souintry) Ssachusetts
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
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	or 28g	Director	10e. Street and Number	7		10f. Zip Code	CI OPILI		g. Citizen of What (	Country?
	ath w		3701 International				20906			d States
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9500-612	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner mast be notified at	by	xz If Yes	, Give or Dates:	'	I∐Yes 2ÅNo	Specify:		Specify:	White
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Mar	12 sh th and 7 is m traum	179	19a. Informant's Name/Relationship (Type. Print)			g Address (Street an				
a)	t and 2 f Health tem 27 i		Eric Johnson/ Son  20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of			Pennsylv. Oc. Location - City of	ania 19438 or Town, State
Ë	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State		natory or other place) dical Scho	Febr	uary 2009 B	oston. Ma	assachuseets
Бащто	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any Injury or other traumatic.		21. Signature of Fundal Service Licensee	,					umphrey 7557 Wis	Funeral Home/ consin Avenue
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Y.	The lay	Completed						autopsy performe	ed? prior t	o completion of cause of
Vital	ctor, p	BeC	25. Was case referred to medical examiner?			2	26. Place of Deat	1 □ Yes 2 (Check only one)		es 2□No
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0	ding th.	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Pate of Injury Wonth, Day, Year)	28b. Time of Injury	Work?	at es 2 □ No	28d. Describe how	v injury occurred	
UIVISION	Atter ector by the	Certification:	a Do : : L G Could not be	lace of Injury - At hon uilding, etc. (Specify)	ne, farm, str			28f. Location (Stre City or Town,	eet and Number or	Rural Route Number,
5	ital or irs afte ral Dir lled in	Cert	N							Y
	To the Hospital or Attending Physician: The law requires that the death cer within £4 hours after death. To the Tuneral Directors After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To 2 Medical Examiner: On t and	the best of my know he basis of examination manner stated.	rledge, death on and/or in	n occurred at the time vestigation, in my opi	e, date and place, nion, death occur	and due to the car red at the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License r		29	d. Date signed (Mo	nth, Day, Year)
	13		) 25/2 A DAI	m. 5		D 53	317	f	obreary	14, 2009
	17		30. Name and address of person who completed	( 1 -	1		641ther	slo h	10 2087	1-7
	Sta	te	31. Date filed (Month, Day, Year) - 3	2. Registrar's Signatu		1213	U 411 V(E).	Wary M	10 W8	/
	Registr		property of the comme	1	1	1				1

		For State of Maryland  1 - State Registrar		tificate of E		nentai myg R	eg. No. 2009	04519
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/Medica Examine	er	4a. Facility Name (If not institution, give street and number)			Location of Death	•	4c. County of Deat	
Funeral		The Johns Hopkins Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	N/J	hplace (State or Foreign untry)
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ryland how		10a. State 10b. County 10c. City,	Town or Loc				, , , , , , , , , , , , , , , , , , ,	10d. Inside City Limits
he Mar 28a-f s otiffed	ecto	MD Baltimore C  10e. Street and Number	atons	sville 10f. Zip-Code		1	0g. Citizen of What Co	1 ☐ Yes 2 X No
death with the Maryland ms 23a or 28a-f show must be notified at	a Di	6 Madison Mills Court		21228	3		USA	unity:
ie ie e	by Funeral Director	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 <b>X</b> No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
"natural", or	ted k	15. Decedent's Education		dent's Usual Occup		kina	16b. Kind of Business	
vithin 7 ne. han "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  5+	life. L	cher		Wing	High Sc	hoo1
a filed v	Be Co	17. Father's Name (First, Middle, Last)	Teav	circi	18. Mother's Nar	ne (First, Middle,	Maiden Surname)	1001
	P B	Kim UNK			Ubo1	Punja		
<b>443</b> 0 <b>5</b>		19a. Informant's Name/Relationship (Type. Print)  Pricha Kwunyeun – husband					r, City or Town, State, 2	Zip Code) Land 21228
or Heal of Heal ritem 2		20a. Method of Disposition  20b. Pla  20c. Method of Disposition  20b. Pla  20c. Planeting 2 Pennoval from State	ace of Dispo	osition (Name of matory or other place	e)	Date	20c. Location - City or  Baltimore	Town, State
Baltimc permit. Pag Department Important: It any Injury o		21. Signature of Funer Stewerine He Williams	22	Cremation	society	of Mary	land, Inc.	
	1	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Ovarn'ar		ancer				Onset and Death
/Medical Examiner		Due to (or as a conseque	ence of):					
/ D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):					
xecuted and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence of the consequenc	ence of):					
		d						
death certificate be executed eattending physician and ed for use as the burial-transi	sician/Medical	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of the past 12 months?		Ectopic pregnanc	y		23d. Date of de	livery Day Year
C. E.	Physic	1   Yes 2   No 4   Pregnant at time of dea 9   Unknown 9   Unknown	ath 5	Other (specify)	-			
E 00	þ	Part II. Other significant conditions contributing to death but not result	Iting in the u	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute t es 2 □ No 3 □ P	to the cause of death?
has ge 2	Completed					24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of
Vital sician: Th certificate irector, pa	Be C	25. Was case referred to medical examiner?		Oth		th (Check only on	-	
Of Phys this c	၉	1 Yes 2 No	R/Outpatien 28b. Time o	of 28c. Injur	4 🗆 Nursing H		ence 6 Other (Spe	cify)
VISION Attending death. ctor: After y the fune	ation	Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Worl				
- FEFC	Certification:	3 ☐ Suicide 6 ☐ Could not be determined building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number or R n, State)	lural Route Number,
To the Hospital of within 24 hours af To the Funeral Discompletely filled in	edical	29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and manner stated.						
To the within To the comple	Me	29b. Signature and title of certifier	110	29c. License	e number	2	29d. Date signed (Mont	th, Day, Year)
		1-/2-2			5000		02/13/2	1009
3		30. Name and address of person who completed cause of death (Item Kim P. Reiss	23a) (Type,	Print)	600	North Wo	lfe St, Baltim	ore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	re A. A	barkel				

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:15 AM Eileen FEBRUARY Karvar 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec. 7, 1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 T F 215-42-5132 M Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experient mast be realified at 1 □Yes 2 No Director Anne Arundel Glen Burnie 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number 603 Pamela Road 21061 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 No Specify White 2 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Administrator Kimbrough Rospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John A. Dyson Jane Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2864 Dover Lane #203 Falls Church VA. 22042 Mr. Patrick Karvar/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 17, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Crownsville, MD Maryland Vets. Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral/Service Lensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACQUIRE Sided Physician CENTHUNITY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 5 Other (specify) I∐Yes 2 1 No After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknowf 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 🗷 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours are death To the Funeral Director: After t 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who compland cause of death (Item 23a) (Type, Print) HOSPITAL 301 HOSPITAL BWMC ARORA SINGH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 Registrar

DHMH 17 Rev 1/2001

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09-01265 Shane Keppley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland / Department of H	ealth and Mental Hygiene

2009 0452

			- For State		Certific	cate of	Death			R	eg. No.	20		0432
edic	Physicia al Exami	ın/	egistrar  1. Decedent's Name (First, Middle, Shane C. Keppl			T				Date of Dea Month February	Day	Year 09		Time of Death D351 hrs
	)		4a. Facility Name (if not Institution, 200 block W. McComa	give street and number	er)	4	b. City, Town, o	or Location o	f Death		4c.	County of D		
	Funeral Director		5. Social Security Number		Age (In yrs. last bi	rthday) Yrs.	If Under 1 Ye		Min.	8. Date of Bi		F	. Birthpla oreign Countr	ace (State or /) MD
MD 2424E 0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	3 Widowed 4 Divo 15. Decedent's Education (Special Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Kelly Alan Kelly Alan Kelly A. Kepp 19a. Informant's Name/Relationsh Kelly A. Kepp 20a. Method of Disposition 20a. Method of Disposition 21buy Alan Cremation	Street  12. Was Decede Armed Force 1 Yes rced If Yes, Give Year or Dates fry only highest grade of College (1-4 of 3 Last) Depley, Sr. Ley, Sr. Fa	2 X No completed) 16a or 5+) 16a ther 20b. Place State Mead	13. Wai If You 1	Lanso  10f. Zip Code  2 s Decedent of It ses, specify Cub  Yes 2 X 's Usual Occup set of working It ok  Address (St Poulto ition (Name of	21227 Hispanic Origan, Mexican, No specify: Dation (Give In DO NOT  18. Mother Anguere and Num On Street	kind of word use retired  "S Name (F gela nber or Ru eet,	rk done  Tirst, Middle,  M. Perral Route No.  Lansdo	16b. Ki E11 In, Maiden S ase Imber, Cit Owne	14. Race - A White, & White, & Specify: \( \sqrt{ind of Busin kridge} \)  kridge  nn  Sumame)  ty or Town,  MD \( \frac{1}{2} \)  .ocation - C	Country of Simulation of Simul	tates Indian, Black, e sstry rnance
	Physician   Medical   Medi		21. Signature of Funeral Service I  23a. Fart I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	c mplications that cause on each line.	sed the death. N	22. Not enter t		nonds	y Amb Fry R	orose Rd., L	Fune: ansd	ral Ho owne,	MD :	Inc.
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co									+	
	cuted nd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):								1	
	exectian a		X UNPENDED	a. AMENDED 2	3a,27,28	a-f,p	erME,	g890 4	/23/0	09 TT				
0	<b>BOX 667 6U,</b> death certificate be the attending physicial of for use as the buris	siciar	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?	e 1 Live birt	tcome of pregnand h nt at time of death	2 F	etal death ther (Specify)	3 Ectop	ic pregnan	псу	230	d. Date of d Month	elivery Day	Year
(	res that the d signed by the	by Phy	Part II. Other significant condit			Iting in the	underlying cau	se given in P	Part I.				_	e cause of death?
	ords law requi has been 2 should	Completed								1 Ye	topsy rformed?	pri de		osy findings available appletion of cause of 2 No
	ital KeC sician: The s certificate irector, page	Be	25. Was case referred to medica examiner?	Managhali, and	patient 2 ER	₹/Outpatien		Other		Home 5	Reside	ence 6 🗸	Other: S	cene
	n of VI ding Physi n After this funeral di	on: To	1 Yes 2 No  27. Manner of Death  Natural 5 Pend	28a. Date of (Month, D	f Injury 28 Day, Year)	Bb. Time of	Injury 28c.	Injury at Wor	rk?	28d. Describ			d	
	DIVISION pital or Attendit ours after death reral Director: Affilled in by the fu	Certification:	2 X Accident inver	stigation Fu Z/	of Injury - At home overpas	e, farm, stre	eet, factory, offi	ce building, e		28f. Location or Town St Bal	n, State)	200 B	1k.	Route Number, City W . McComas
	DIVIS  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner:On the basis of	examination and/	death occu	urred at the time ation, in my opi	e, date and p nion, death o	place, and occurred at	due to the ca t the time, da	ause(s) ar ate and pla	nd manner a ace, and du	as stated e to the	cause(s)
4	To wi	Mec	29b. Signature and title of certific	and manner sta	17			ense numbe	er			Date signe oruary 13		n, Day,Year)
			30. Name and address of persor  Russell Alexander MD		of death (Item 23 edical Examin	Ba) ner 11	1 Penn Stre	eet, Baltim	nore, MI	O 21201				
	5	tate			istrar's Signature		when							

			1 _ State	partment of Health and Mental Hy	-
			Registrar	2. Date of De	
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Joseph James Kalinowski	Februa	
	Examin	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
-			Bayview Medical Center	Baltimore City    If Under 1 Year   If Under 24 Hrs.   8, Date of Bir	
ı	Funeral Director	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 F 7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Bir (Month, Days Hours Min. Apr 22	9. Birthplace (State or Foreign Country) Maryland
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	pcation	10d. Inside City Limits
	e Maryla 8a-f sho	ctor	Md. Balt:	imore City	1X Yes 2 No
	or 2	Ë	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w	<u>ra</u>	2509 Eastern Avenue	21224	U.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination invaries notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>□ Yes 2 Xno Specify:</li> </ol>	o- 14. Race - American Indian, Black, White, etc.  Specify: White
ō	2 hou	led	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16b. Kind of Business/Industry
21215-0036	within 7% iene. • than "n	Completed by	Elementary/Secondary (0-12)   College (1-4015+)	re kind of work done during most of working . DO NOT use retired)  tter Carrier	USPS
and 2	I be filed intal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last) Stanislaw Kalinowski	18. Mother's Name (First, Middle Adela	
Maryland	12 should h and Me 7 is mark fraumatic	은	19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Ma	iling Address (Street and Number or Rural Route Numb Bastern Avenue Balt	
	1 and Healt Sm 27				20c. Location - City or Town, State
Baltimore,	int of			rematory or other place)	
Ē	it. Pertrant			osary Cem.  2-14-2009  22. Name and Address of Facil Kaczorows	Baltimore, Maryland
Ba	permi Depa Impoi any Ir		> Tobat / Solere ):	1201 Dundalk Avenue B	altimore, Md.21222
100	Physician /Medical		23a. Part 1. Enter the disease or complications that caused the death. Do not e shock, or heart failure. Est only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a	eart failure  ear Disease	Approximate Interval Between Onset and Death
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and trail director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	ery Disease	
P.O. Box 6	ires that the death certifi signed by the attending I be detached for use as	Physician/Med		B □ Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
	that ned b		Partil. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	tobacco use contribute to the cause of death?
rds	quires n sig ald be	d by	Dialseter Mellity:	1_	Yes 2 No 3 Probably 4 Unknown
of Vital Records,	ysician: The law requir is certificate has been s director, page 2 should I	Completed	Ventradar Tacycardia	24a. Was auto perfo	
/ita	ician: The certificate ector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only of	one)
7	Physic this c		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 X ER/Outpat	ient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Resi	idence 6 Other (Specify)
Division o	ending Path. or: After i	ation:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time Injury		how injury occurred
Divis	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and the of certifier	29c. License number DO 2 2 4 7 2	29d. Date signed (Month, Day, Year) February 12, 2009
	ζ.,		30. Name and address of person who completed cause of death (Item 23a) (Type Dr.Peter A. Holt, M.D. 5601 Loc	e, Print)	
	3. V				,

DHMH 17 Rev 1/2001

Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, fro Medical Examination in Aithor at once.

**Physician** 

Examiner

**Funeral** Director

/Medical

Directo

Be Completed by Funeral

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For	State o	ot Mar	yland / I	Depa	artme	nt of h	realtr	n and r	Mental Hyg	iene	
For State Registrar				Cei	rtifica	te of	Deat	h	Re	eg. No. 20	09 0452
I. Decedent's Name (First, Midd	e, Last)								Date of Deat     Month		3. Time of Death Year
Yolanda M. Li	loia								February		
a. Facility Name (If not institution	n, give street and nu	ımber)			4b. City	, Town, o	r Locatio	n of Death		4c. County o	f Death
Stella Maris						Timo	nium	1		Balt	0.
Social Security Number	6. Sex	7. Age (	(In yrs. last bi	rthday)		er 1 Year Days	If Und	er 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
47-09-0390	1□ M 2\□ F	88	3	Yrs.	Months	Days	Hours	S IVIIII.	December	20,192	0 Newark, N.J
sual Residence of Decedent											
a. State 10b. County		1	0c. City, Tow	n or Lo	cation						10d. Inside City Limits
Md. Har	ford				AŁ	ingd	on				1 □ Yes 2√□ No
e. Street and Number					_	ip Code			11	0g. Citizen of Wh	hat Country?
16 Mitchell D	rive					210	09			U.S.A	
. Marital Status	12. Was Dec	edent Eve	er in U.S.	13. \	Was Dec			Origin? (S	pecify Yes or No- Dican, etc.)	14. Race	- American Indian,
1 ☐ Never Married 2 ☐ Mai	Armed Fo	orces?		1			an, Mexi	can, Puerto	Rican, etc.)	Black	, White, etc.
3 ☑ Widowed 4 ☐ Divorced	If Yes G	ive 🔭			1 □ Yes	2 <b>∑</b> No	Spec	ify:		Specify:	White
21	nt's Education		16a	a. Dece	dent's Us	ual Occur	ation			16b. Kind of Bus	siness/Industry
(Specify only high	st grade completed)		-4	(Give	kind of w	ork done use retire	durina m	ost of worl	king		•
Elementary/Secondary (0-12)	College (	1-4or 5+)	1				•	rato	r	Clothi	no
'. Father's Name (First, Middle	Last)		19E	M T II	<u>s riac</u>	-IIIIIC			ne (First, Middle, M		
,									Touzzola		,
Antonio Coppo											
9a. Informant's Name/Relation	, , , ,				-				ral Route Number		
Patricia Calc	ado							e Ar	oingdon,		
Da. Method of Disposition	0	01-1-	20b. Place o	of Dispo ery, crer	sition (Na natory or	ame of other pla	ce)	• • •	Date	20c. Location - C	City or Town, State
1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State	Glend	ale	Ceme	etery	,	2-18-	-2009	Bloomfi	eld, N.J.
Signature of Funeral Service								<u> </u>	nimunek I	Funeral	Home
Stypus	io K	m	Ron	6	510 V	V. Ma	cPha	il Ro	i. BelAiı	r, Md. 2	21014
3a. Part1. Enter the disease, o	r complications that	caused th	ne death. Do	-							Approximate
shock, or heart failure. Lis mmediate Cause (Final						,	,		, , , , , , , , , , , , , , , , , , , ,	,	Interval Between Onset and Death
isease or condition esulting in death)	a. SEPSI	S									
and an addition	Due to	(or as a	consequence	of):							
equentially list conditions,	b										
any, leading to immediate ause. Enter Underlying	Due to	(or as a	consequence	of):							
at initiated events	c										
esulting in death) Last	Due to	(or as a	consequence	of):							
	d										
										- UI	
F FEMALE:	23c. If yes, ou	utcome of	pregnancy							23d Data	e of delivery
3b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2	Fetal deat		Ctopic	pregnand	су			Mon	· ·
1 ☐ Yes 2 <b>X</b> No 9 ☐ Unknown	9 Unk		ine or death	ΣL	_ ∪ther (	specify) _					
art II. Other significant condit	ions contribution to s	death hut	not resulting	in the :	ndarlvina	Called Cit	an in Do	rt I	23e Did to	nacco use contril	bute to the cause of death?
aren. Omer signineant condit	one community to t	Jean Dul	not resulting	iii ai <del>e</del> u	nuenying	vause gil	ren III Pa	ich.		_	
		_							1 ☐ Ye	es 2 <b>X</b> No 3	3 Probably 4 Unknowr
									24a. Was a	n 24b. W	Vere autopsy findings available rior to completion of cause of
							-		autops perforr	<u>ne</u> d?   de	eath?
5. Was case referred to medic	u			_							□Yes 2□No
examiner?	Hoonital:					. 011	201:		th (Check only on		TO CRECE
1 Yes 2 No	1 1		t 2 ER/0			-		Nursing H	1		er (Specify) HOSPICE
27. Manner of Death	28a. Date	e of Injury <i>nth, Day</i> , '	28b.	Time o	I.	28c. Inju Wo	rv at		<ul> <li>28d. Describe ho</li> </ul>	ow injury occurre	d

Physician/Medical Examiner within 24 hours after death.

To the Funeral Circector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Be Completed by Division of

**Physician** /Medical Examiner

> in the pa 9 Unk Part II. Other 25. Was case examiner Medical Certification: To 1 ☐ Yes 27. Manner of 1 X Natura investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier (Check only one) X Nurse Practity one best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> Nurse Practity one; Stated. 29a. Certifier

29c. License number

State Registrar

HAUF. CRNP 31. Date filed (Month, Day, Year) -

7 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2116/2004

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>□</sup>13, 2009 February **Physician** 6:00 P M Ruthe Arlene Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Holly Hill Manor Nursing Home Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/4/1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F 87 Maryland 214-14-0073 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygisen. 1 ten 27 is marked other than "natural", or items 23a or 28a-f show other than matural.", or items 23a or 28a-f show other traumatic event, I'm McGoot Exp. in a continue to rollified at 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 ☐ Yes 2 No MD Baltimore Funeral Director Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 579 Brook Road 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 XXVo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√√No Specify: Specify: White <u>ک</u> 3 ¥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Rebert Elsie Hill ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any Injury or other traum once. Lauren Lee / Daughter 579 Brook Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 2/17/2009 |Baltimore, Maryland Towson, Maryland 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleration Cardovasala **Physician** disease or condition resulting in death) 107 vot /Medical Due to (or as a consequence of): Syvot Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pue to for as a consequence of that the death certificate be execute ysician and e burial-trans demento Due to (or as a consequence of) Box 68760, Physician/Medical phy: the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 1 ☐ Yes 2 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Gutur street 6

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) February 13, 2009 2:45 p м Levin Matilda Κ. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death n/a Baltimore Future Care-Lochearn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jay, Jan 31, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Days 92 T917 212-01-3832 Mary Tand Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 X Yes 2 □ No Baltimore MD n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21215 4800 Seton Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **\N**o 1 □Yes 2 🛣 No Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miller Agnes K1itz Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry Rollings-daughter 154 Carroll St Apt C,S.E. Atlanta, GA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/17/09 Towson, MD Hilltop Serv Corp 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Servi Censee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vascular nertensive 1ears disease or condition resulting in death) Due to ( r is a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 22 No Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2-No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural Iniury 5 Pending 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed use as the burial-tran and Box 68760, physician ō signed by the a Ö ۵. Division of Vital Records, has e 2 s page this certificate To the Hospital or Attending Physician: director.

**Physician** 

/Medical

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

ည

Examiner

Physician/Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Evanders 200 or 28a-f show once.

After th funeral within 24 hours after death.

To the Funeral Director: Α
completely filled in by the fu

Completed by Be Certification: To Medical

Registrar

ZIDEVI 31. Date filed (Month, Day, Year, State

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

investigation

determined

6 ☐ Could not be

30. Name and address of person who com eted cause of death (Item 23a) (Type, Print) Mar 25 MU 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1737573

He certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 16, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Resolecter

37

State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY Day 7 2009 **Physician** 10:50 PM LIBURD ODESSA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL 8. Date of Birth Month, Day, JAN 26 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days <sup>Year)</sup> 1933 Hours 1 □ M 2 🔀 F Months NORTH CAROLINA 76 228-44-6252 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shoi other traumatic event, Ins Medical Exeminar mast by motified at 1√2 Yes 2 □ No Director UPPER MARLBORO PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 USA 1077 LARGO ROAD Funeral 2 should be filed within 72 hours after death v n and Mental Hygiene. is marked other than "natural", or items 23: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 【 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT CUSTOM INSPECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENA BATTLE WHITHEAD FRED ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2831 EXTERIOR STREET BRONX, NEW YORK 10463 ANITA P. GRAHAM/DAUGHTER item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State LEW CEMETERY | 2/14/2009 | ENFIELD, NORTH CAROLINA 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME CEDAR VIEW CEMETERY 2/14/2009 4 Depation 5 □ Qther (Specify) 21. Signature of Funeral 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BRAIN METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed PULMONARY EMBOLISM ending physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy after for u in the past 12 months? Year Month Day 5 ☐ Other (specify) signed by the a d be detached f Ö 9 Unknown σ. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 has autopsy certificate 21 No 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospital: 14 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attenaurs a er d'ath. Ars a er d'ath. Ar Aftr 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058213 8/9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 FARHAD JAMALI M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#31perPHYS C888, 2/17/09 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month LONDON JOSEPH 3 1 1 2 1 7:05 February 11, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Greater Baltimore Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/07/1942 5. Social Security Number 6. Sex 1 X M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 219-38-5055 66 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X1No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SUDBROOK LANE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No WHITE Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN LONDON UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA QUEEN / SOCIAL WORKER 7 SUDBROOK LANE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 02/12/2009 BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Approximate Interval Between Onset and Death JWEEK Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Pronknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 🖸 No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Yes 2 No

Examiner Hospital or Attending Physician:

jo within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or Items 23a or 28a-f shov edical Examiner must be notified at

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any Injury or other traumatic event, i

**Physician** 

/Medical

Director

by Funeral

Completed

Be

2

Examiner

Physician/Medical

Medical Certification: To Be Completed by

25. Was case referred to medica examiner?
1 ☐ Yes 2 ☑ No

27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

(Check only one)

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated.

30. Name and address of person who completed cause of death (Kem 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

To the !

09-01235 Richard Lawson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Re	For State		rtificate of	Health and Death		Reg.	No. 21	09 0452
Physician/ cal Examine	1.	Decedent's Name (First, Middle,Last)	Lawson				2. Date of Death  Month D  February 10	ay Year , 2009	3. Time of Death 1742 hrs
	48	i. Facility Name (if not institution, give street an Franklin Square Hospital	nd number)	4	b. City, Town, or Lo Rosedale	ocation of Death		4c. County of D Baltimore (	
Funeral Director		Social Security Number 6. Sex-	7. Age (In yrs. I	ast birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min			Birthplace (State or Foreign Country)
any	_	sual Residence of Decedent  a. State 10b. County	10c. City	, Town or Locati	on				10d. Inside City Limits
<u> </u>		MD Baltimore		Catons	ville				1 X Yes 2 No
72 hours after death with the Maryland n"matural", or items 23a or 28a-f show at Examiner must be notified at once. eted by Funeral Director	10	De. Street and Number			10f. Zip Code 21228		10g	. Citizen of What USA	•
s 23a o e notifi		6 Melvin Avenue	Decedent Ever in U	l.S. 13. Wa	S Decedent of Hisp	anic Origin? ( S	pecify Yes or No-	14. Race - A	merican Indian, Black,
or items 23		Never Married 2 Married 1 Y	ed Forces? 'es 2 X No	If Yo	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White, e	White
miner by F	≥ ਂ	B Widowed 4 X Divorced If Yes, Given Dates:  15. Decedent's Education (Specify only highes)			Yes 2 X No		work done 1	Specify: 6b. Kind of Busin	
ed within 72 hour tygiene.  other than "natr he Medical Exar	eted  -	Elementary/Secondary (0-12) Colle	ege (1-4 or 5+)	during me	ost of working life. I	DO NOT use reti	red)		house
led within 72  Tygiene.  other than  he Medical	dwo 1	7. Father's Name (First, Middle, Last)		F	orklift C	_	(First, Middle, Ma		nouse
	اه		awson		1"			eager	
hould be is mar is mar		9a. Informant's Name/Relationship (Type, Print	,		Address (Street				
is 1 and 2 s of Health at If item 27 ner trauma	2	Brandy Smead / Dau Da. Method of Disposition	20b.	Place of Dispos	3 Bearrid ition (Name of cem	lge Road <sub>etery,</sub>	, Apartme	ent 202, 20c. Location - Ci	Baltimore, MI ty or Town, State 21222
ages I and nt of Health it: If item other trau	1	Burial 2 X Cremation 3 Remo		crematory or other dent Cre	ner place)	1	/14/2009		ver, MD
permit. Pages I an Department of Hea Important: If ite injury or other tra	2	Donation 5 Other Specify:  1. Signature of Funeral Service Licensee Do		22 N	lame and Address	of Facility	on Sorvi	705	
		3a. Part I. Enter the disease, or complications			Maryland Po Box 14	13, Bal	timore, I	MD 21203	- Approximate Interval
nysician Medical xaminer		failure. List only one cause on each line.  mmediate Cause (Final disease a. Com)	plications	s of met	chadone a			i, shook, or hour	Between Onset and Death
		sequentially list conditions, b.							
i di	∍ا⊒	ause. Enter Underlying Cause	r as a consequence						
recuted		vents resulting in death) Last Due to (o	r as a consequence	of):					
e be execu ysician and burial - tra	edical	XUNPENDED AMENI	DED 23a,PI	I,27,28a	a-f,perME	, g890	4/9/09 T	C	
e death certificate be the attending physic ed for use as the bur		b. Was decedent pregnant in the	yes, outcome of pre-	_	etal death 3	Ectopic pregn	ancy	23d. Date of de Month	livery Day Year
eath certificate eattending phy for use as the	Physician/M	past 12 months?	Pregnant at time of d	le eth	ther (Specify)				ŕ
the dez			Unknown ting to death but not	resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
signed be deta		Cocaine use					1 Yes	2 No 3	Probably 4 V Unknown
w requir	Completed by						24a. Was ar autops	y pric	re autopsy findings available or to completion of cause of
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To the Hosp within 24 ho To the Func completely fi	10 1	9a. Certifier 1 Certifying Physician: To the Check only one) 2 ✓ Medical Examiner: On the l	pasis of examination	dge, death occu	rred at the time, da	te and place, an	d due to the cause at the time, date a	(s) and manner a	s stated.  to the cause(s)
To To COM	Mec 2	9b. Signature and title of certifier	nner stated.		29c. License				(Month, Day, Year)
		MOS	7/1	n1	O.C.	И.Е. 		February 12,	2009
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/Medic		Eleanor			_						2-200	09	453 A M
Examin	er			n, give street and number,					r Location of Deat	h	4c.	County of Dea	
		3813 Haz		0.0		In ad hindhaland		ingdo		Dotto of B	ieth	Harfor	
Funeral Director		5. Social Security N 106-28-1		6. Sex 7. Ag	7 2	last birthday) Yrs.	Months		Hours Min.	8. Date of B (Month, E	Day, Year)	9. Bir	rthplace (State or Foreign ountry)  NY
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or 28	Dire	10e. Street and Nu					10f. Z	ip Code			_	izen of What Co	ountry?
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should be filled within 72 hours after death with the Maryland and Mental Hygiene. In a marked other then "natural", or items 23a or 28a-f show umetic event, the Medical Evaning must be notified at	Be C	17. Father's Name		,					18. Mother's Nar				
uld b Menta arked	To E	George M	latthew:	S					Catheri	ne Lop	icola	1	
sho and is me		19a. Informant's N					-		and Number or R				Zip Code)
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If then Z7 is marked other then "natural", or items 23a or 28a-f show any Injury or other traumetic event, the medical Evanties must be notified at once.		21. Signature of F	uneral Service	Licensee					ess of Facility Sc	himunek	Fune	eral Ho	me of BelAir
00280		On Post Fater	en C	. UUU					V. MacPha			r, MD 2	1014 Approximate
		shock, or hea	art failure. List	complications that cause only one cause on each I	ine.	in. Do not em	ter the m	Jan 2	ng, such as cardia	c or respiratory	arrest,		Interval Between Onset and Death
Physician // /Medical		disease or condition resulting in death)	on	a	+	) em	en	ha					years
Examiner				Due to (or as	a conseq	juence or):							
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Ing P	0	27. Manner of Dea 1	5 Pendin	28a. Date of Inj (Month, D	ury a <i>y, Year)</i>	28b. Time o Injury		28c. Inju Wor		28d. Describe	e how injur	ry occurred	
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or A after Direc	Certification:	4 Homicide	determ	28e. Place of In building, e	tc. (Speci	ify)	reet, racti	ory, office			own, State		Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funerial Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	C E	29a. Certifier		ng Physician: To the bes									
n 24 h	edical	(Check only one)	2 ☐ Medical	Examiner: On the basis and manner s		ation and/or ir	nvestigati	on, in my	opinion, death occ	urred at the time	e, date and	d place, and du	e to the cause(s)
Vithii To th	X	29b. Signature and	/	r M.T			2	29c. Licens	se number		29d. Da	ite signed (Mon	th, Day, Year)
<b>S</b>		1	Nos(a	11				D.	2024	>	2	-116	109
41		30. Name and add	dress of person	who completed cause of	death (Iter	m 23a) (Type,	Print)	102	se number 5 6 5 4 5	AIR	*~	D 2	1014
Sta		31. Date filed (Mo.	nth, Day, Year)	32. Regis	trar's Signa	ature /s	arka	1	-				
Registi	ar	1	FFH 17	ZURN CONTRACT	and the same	10. 12							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time 1. Decedent's Name (First, Middle, Last) **Physician** 2009 Earl Eugene McCarroll /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rarni 6-1en Baltimore Washington Med Center If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Min 1 🔀 M 2 🗆 F 07/30/1923 Arkansas 85 Director 206-12-6082 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "nadical Exemples" in 1811 be not the sta 1 XYes 2 ☐ No Baltimore MD Director Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21225 5208 Disney Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2 🙀 No Specify: White Specify: <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien, Important: If item 27 is marked other than any injury or other traumatic.... Outside Metal Machinist 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Simmons Bertis Dee McCarroll ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5208 Disney Avenue, Baltimore, MD Elizabeth McCarroll/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/17/2009 Hanover, Maryland Anatomy Gifts Registry 4 Tonation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licenses 7522 Connelley Drive, Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last aftending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No nis certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 10 1 ☐ Yes 2 NO 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar 29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

within 24 ho

To the Fune

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the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

72 hours after

altimore, Maryland 21215-0036

0

32. Registrar's Signature

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

mi

09-01186 Mary McKoy

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

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1   Normal State   1   Normal	\ <u>*</u>	. 1	0a. State / 10b. County 1 10c City, Town or Loc			
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Security	ter death with ", or items 23		1 Never Married 2 Married Armed Forces?  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.) White,	
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A Confidence of Figure 2 and Service Updated A	MD 21 nd 2 should alth and Mer in 27 is man	٩	JAMERA Hill (daughter) 6:	28 N. Payson St	· BAltimore	, Md 21223
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me) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29b. Signature and title of certifier  29c. License number O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrer's Signature	P.O. B s that the digned by the e detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		
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29b. Signature and title of certifier  O.C.M.E. February 10, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day, Year)  32. Registrer's Signature	Lette Hospit thin 24 hour fulle Funers mpletely fills	dical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one)  Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and place, and stigation, in my opinion, death occurred a	at the time, date and place, and	due to the cause(s)
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Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32. Registrer's Signature			Curl	O.C.M.E.	February 1	IU, ZUU9
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	is J		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	nn Street, Baltimore, MD 2120	1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PMBernadette Sophie Martin 2009 9:13 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Oakcrest Care Center Parkville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 □ M 2 💢 F 78 216-28-0989 Maryland 12/20/1 9 30 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State MD Baltimore Parkville 1 □Yes 2 N No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 U.SA. 8800 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cordula Hauk James Bateman 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trema Wilcox/ Daughter 4904 Cherry Tree Lame Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 02/18/09 Parkville, MD 21. Signature of Funeral Service Licenses Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immudiate Cause (Final Lease or condition resulting in death)

a. Due to (or as a consequence This Approximate Interval Between Onset and Death Due to (or es a consequence in) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

th and Mental Hygiene.
7 is marked other than "natur traumatic event. The Medical

permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

9

the attending physician and hed for use as the burlal-transit has this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral After 1

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

MARTIN, BERNADETTE

Medical Certificat

The The	무응
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uneral director, page 2 snould be detached for use as the	on: To Be Completed by Physician/Medic
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25.	Was case examiner? 1 ☐ Yes	1	
27.	Manner of		- C

(Check only one)

5 ☐ Pending investigation 2 ☐ Accident 3 Suicide 6 Could not be 4 Homicide

29a. Certifier

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: o the best or my knowle ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier reis CRA

R043580

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

ther BIVd. Balto. Md. 21234-8832 32. Registrar's

and manner stated.

30. Name a d address of person who completed cause of death (Item 23a) (Type, Print)

	1 - State Registrar		Certificate of	Death	Reg.	No.	0 Time of De			
n	1. Decedent's Name (First, Middle, Last)  Elwood Richard Mar	rico i				Day Year	3. Time of De 5.15			
al .	4a. Facility Name (If not institution, give street and no		4b. City, Town, c	or Location of Death	rebruery	4c. County of Dea				
r	VA Maryland Health Care		Parry	Point		Ceci	./			
	5. Social Security Number 6. Sex	7. Age (In yrs. last bi	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or F			
	214-20-9693   XX 20   81 Yrs.   10/03/1927   Ma									
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									
to	Maryland Baltimore	Bal	timore				1 ☐ Yes 2			
Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What United S									
	3009 Edwards Avenue		2123			of Ameri	ca			
Funeral	Armed F	cedent Ever in U.S. Forces? : 2 ☐ No	13. Was Decedent of F If Yes, specify Cub	Hispanic Origin? (Spe van, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	te, etc.			
by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or I	aive	1 ☐ Yes 2 🖾 No	Specify:		Specify:	white			
ted	15. Decedent's Education		a. Decedent's Usual Occup	pation	166	o. Kind of Business	/Industry			
Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College 12	(1-4or 5+)	(Give kind of work done life. DO NOT use retire			14-17 -	l ~			
S			Layout Arti			eliable S	tores Coi			
Be	17. Father's Name (First, Middle, Last)  Albert Roy Marke	1			<i>(First, Middle, Mail</i> ed Englem	,				
9	19a. Informant's Name/Relationship (Type. Print)		b. Mailing Address (Street				Zip Code)			
	Mrs. Naomi R. Markel/ s		009 Edwards							
1	20a. Method of Disposition	20b. Place o	of Disposition (Name of ery, crematory or other pla	rebr	Pate 200	c. Location - City or	Town, State			
	1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Evan Chape	ery, crematory or other pla s Funeral l- Bel Air	18, 2		rest Hil	l, Maryla			
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. 1									
	2325 York Road Timonium, Maryland 21093									
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death									
	Immediate Cause (Final disease or condition resulting in death)  a.									
	Due to (or as a consequence of):									
Jer	Construction that are different									
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.									
al Ex	resulting in death) Last Due to (or as a consequence of):									
dica	d									
Physician/Medica	IF FEMALE: 23c. If yes. o	utcome pf pregnancy				, 23d. Date of de	divon			
cian	in the past 12 months?	Month	Day Yea							
nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown									
by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
					1 ☐ Yes	2 No 3 P	robably 4 Unk			
plet					24a. Was an autopsy		utopsy findings ava completion of caus			
Completed					performed 1 Yes 2	death?	_			
Be	25. Was case referred to medical examiner?		10	26. Place of Death	(Check only one)					
2			dipatient 3 DOA		me 5 Residence		ecify)			
ion	1 Natural 5 Pending (Month, Day Year) Injury Work?  M 1 Type 3 □ No.									
ţ	3 Suicide 6 Could not be 28e. Place	ce of injury - At home, f	arm, street, factory, office		28f. Location (Stree	t and Number or F	lural Route Numbe			
fication	4 ☐ Homicide determined buil	lding, etc. (Specify)			City or Town, S	nale)				
Sertification	29a, Certifier  (Check only  2 Medical Examiner; On the									
cal Certification:		anner stated.								
			29c. Licen	se number	29d.	Date signed (Mon	ui, Day, Year)			
	29b. Signature and title of certifier	MM		~~	21 5	1				
Medical Certification		MD	0)(	082010	781 FE	Spenser 1	5,2009			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2009 1:00 AM FEBRUARY Frankie D. McCluney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE HENES If Under 1 Year | If Under 24 Hrs. | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months 63 1 3 M 2 □ F 244-62-7137 9/12/45 Director NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Evan increust be notified at N/A Baltimore Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 2848 Clifton Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. African 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No ģ <sup>Sp</sup>American 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the "nature." Elementary/Secondary (0-12) College (1-4or 5+) Steel Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John McCluney Ada McCluney ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar.
Important: If item 27 Is any Injury or other trausonce. Shirley A. McCluney/Wife 2848 Clifton Av, Balt., MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt.Rest Cem. 20c. Location - City or Town, State Date 20a. Method of Disposition 2/21/09 King Mountain, NC **№** Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs, PA 21. Signature of Funeral Service License 5126 Belair Rd, Balt.MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician VENTRICUL FORTY DURS disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed HRONIC OBSI attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕰 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 X Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Aft
pletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number ATTENDING CARDIOLOGIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JONATHAN SAF 31. Date filed (Month, Day, Year)

FEB 1

2009

DHMH 17 Rev 1/2001

FRANKIE

3449 WILKENS

Redistrar's Signature

BALTIMORE MARYLAND

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5.25 AM February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HEALTH + ROHAD If Under 1 Year | If Under Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2□F 87 Director 11-20-75 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; if Item 27 Is marked other than "natural", or Items 23a or 28a-f show important; if Item 27 Is marked other than "natural", or Items 2000 or 18 moving the most percent in the Moving Examiner must be notified at some. Funeral Director 1 BYes 2 □ No alumb1A 10e. Street and Number 10g. Citizen of What Country? U5 19 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 →No ρ Specify: BLAC 3 ☐ Widowed 4 M Divorced Ye ar or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PK: 2-14-69 4 ☐ Donation 5 ☐ Other (Specify) WINDSOR-MILL = MMD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Howell 10220 GUILFORD Rd. U Part L. Kmer the lisease, or complications that caused the dor th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dilase Alteroscleratic (Grdw Vas Calar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner and To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-rar Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and d 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Balhmore Maryland 21221 Back RIVER Meck Sapathy 201-109 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 17 2009 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland Department of Health and Mental Hygiene 2 0 0 9

Registrar

State of Maryland Department of Health and Mental Hygiene 2 0 0 9

Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town or Location of Death 4c. County of Death **Examiner** 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Min. 1**X**M 2□ F 33 Yrs. Director Decedent Usual Residence of Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Middoll Evantinar must be notified at 1 √es 2 No **Funeral Director** TMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes If Yes, Giv Year or Dates 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 \$€No 1 ☐ Yes Specify: δ 3 Widowed 4 □ Divorced ac Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/becondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental ပ္ Moore Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) STON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Department of H Important: If ite any Injury or ot once. Burial 2 Cremation 3 Removal from State 4 Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee permit. 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) as been signed by the 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 page 2 certificate 2 □ No 1 ☐ Yes Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Apresidence 6 Other (Specify) Living Hospital: 2 No 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 🔲 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number suga mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 21228 many 31. Date filed (Month, Day, Year) 32. Registrar's Signature State acks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEMORALLARY 9. **Physician** ¥921/219 2:25 FM James P. McManus. Jr. /Medical 4c. County of Death Haltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 12, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours 1 □ M 2 □ F 78 Mar 052-24-1073 New York Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10h County 10c City Town or Location 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21093 10 Lochmoor Court USA items 23a Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item
any injury or other traumatic event, the Wedcal Eventhand 1 □ Yes 2 □ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ white 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Account Executive News Paper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James P. McManus, Sr. Florence Keane 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. McManus, III Locksley Court; Phoenix, MD 21131 / son 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 ☐ Removal from State Garrison Forest 2/13/09 5 ☐ Other (Specify) Owings Mills, MD 4 Donation 21. Signature of F) ne a Service 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BILIARY/BOWEL ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed RESPIRATORY FAILURE physician and s the burial-tran Due to (or as a consequence of) RENAL FAILURE Physician/Medical attending p IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ CONGESTIVE CARDIOMYOPATHY 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed?

1 □ Yes 2 🗓 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To this 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation death. 1 ☐Yes 2 ☐ No after death

Director: A

d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2.

DHMH 17 Rev 1/200

Division of Vital Records, P.O. Box 68760,

State Registrar RICHARD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINTHICUM,

7621

M. D. .

32. Registrar's Signature

29c. License number

31826

OSLER DRIVE.

29d. Date signed (Month, Day, Year)

MARYLAND 21204

TOWSON,

Box 68760, P.O. I Division of Vital Records,

Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 permit. Pages 1
Department of H
Important: If iter
any Injury or ott **Physician** /Medical **Examiner** the Hospital or Attending Physlcian: The law requires that the death certificate be executed Certification: To To the Funeral Director: After the completely filled in by the funeral within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D64395 FEBRUARY 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 6565 NCHARLES ST, SUITE ZOG BALTIMORE, MO 21204 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12, 2009 **Physician** 11:55 p <sup>M</sup> February Dorothy Caroline Maykrantz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Middle River 17 Longeron Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/18/1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2X F 82 205-14-0318 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 1XYes 2 No Middle River MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 USA 17 Longeron Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Completed by 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Seamstress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Lewandowski Mary (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 112 Whistle Stop Road, Middle River, MD 21220 Gloria Morgan / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 02/13/2009 Hanover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
Po Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensed Dorota Marshall NSluga 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ementa Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and is the burial-tran: resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 9□Unknown Day in the past 12 months? 1 ☐ Yes 2 ■ No 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 86 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 【Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of conflier 10044296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 705 Digital Drive, Suite G, Linthicum Heights, MD 21090 Rutigliano, M.D. Marian 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

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Koger Lewis Mason Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene UNK UNK 1. For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day January 28, 2009 1520 hrs **Medical Examiner** Roger Lewis Mason 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 713 N. Pulaski Street If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign 8 Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 1 X M 2 F Yrs 10-16-1932 VA 76 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Baltimore 28a-f show N/A MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 713 N. Pulaski Street Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married 1X Yes Specify: African American Yes 2 X No specify: Yes, Give Year Widowed 4 Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) vernit. Pages I and 2 should be filed within 72 hou vepartment of Itealth and Neparla Hygiene. portant: If item 27 is marked out ury or other transment. Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) Printing Unknown Artist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis Mason Virginia A. Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2701 Liberty Heights Ave Baltimore, MD 21215 Angelo Clary, Sr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Metro Crematory Burial 2 X Cremation 3 Removal from State Catonsville Owings Mills, MD 02-2009 Donation 5 Other Specify: 22. Name and Address of Facility Wy 1e mera ome P.A. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 Thir I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDEDItem#5perfh,g888,2/19/09,WS
Item#20b,b,perFH UNPENDED the attending physician ed for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c, If yes, outcome of pregnance 23b. Was decedent pregnant in the Live hirth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months' Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 ✓ Yes 2 Nο 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient DOA this 1 🗸 Yes ۵ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Nedical** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number January 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04542 State of Maryland / Department of Health and Mental Hygiene 19 for State Registrate Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Thomas 1505 Moore Andre bruary 2009 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Battimore pallstown Seasons Hospico - North Nest If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Ol Ol 944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1**X**M 2□ F 217.40.150 (d) Yrs. MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "naturar", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Baltimore Pikesville MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 503 Shannock Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces2 14. Race - American Indian Black, White, etc. 1 ∏Yes 2 **™**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Back 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Chef Kestaurant 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnson Inomas John 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6936 Rockflelds Road Baltimore MW 21244 Todd Moore 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 02/18/09 Arbutus Cometen 4 ☐ Donation 5 ☐ Other (Specify) Greene Fundral SIGS 22. Name and Addra s of Facility Vausnn 21. Signature of Funeral Service Licenses Vaugh C. L Randallstown MD 21133 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear failure. List only one cause on each line. Immediate Cause (Final **Physician** spirating railing disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a conec Examiner has been signed by the attending physician and le 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No g | Unknown g 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 124 hours after deam. Re Funeral Director: After this certificate Intelety filled in by the funeral director, pag 2 No 2 🐼 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 5 ☐ Residence 6 ☑ Other (Specify) Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Time of 28d. Describe how injury occurred 27. Manner of Death 1 ANatural 5 ☐ Pending 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 14459 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avonue Suite 203 Baltimore MD Buton

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -Month Year **Physician** 26AM VIVIAN S. MANEKIN 2009 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY N/A UNION MEMORIAL HOSPITAL 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 04/10/1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M X □ F Min. 199-34-6607 PΑ 94 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mast be notified at 1 Y Yes 2 □ No Director BALTIMORE N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21218 3704 N. CHARLES STREET, APT.1506 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify: WHITE Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is marked other than TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ **ABRAHAM** SPIEGLEMAN KATHERINE BITTMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and;
De artment of Health
Important: If item 27 i
anv injury or other tra 3704 N. CHARLES STREET, APT. 1506 BALTIMORE, MD 21218 BERNARD MANEKIN/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State CARROLL CREMATION 5 ☐ Other (Specify) 02/16/2009 | HAMPSTEAD,MD 4 Donation 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran physician and Physician: The law requires that the death certificate be exe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 mont Month Day Year 5 ☐ Other (specify) 9 I Unknown 9 🗀 Unknown funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 2 SR/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death filled in by the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, To the Hospital within 24 hours a To the Funeral L

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D State Registrar

29b. Signature and title of certified

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year

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32. Registrar's Signature

29c. License number

29d, Date signed (Month, Day, Year)

			For State Registrar	State of M	aryland /		artment rtificate			and Me			009	045	بايا
			Decedent's Name (First, Middle, La	st)						2	. Date of Death	1		3. Time of	Death
	Physicia		Joseph W. Minor	s. Sr.						Fe	Month bruary	Day 11	Year 2009	1630	$\mathbf{P}^{M}$
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, T	own, or	Location o				ounty of Death	1 2000	
			Western Correction						rland			I	llegan		
	Funeral		5. Social Security Number 6. S	Sex 7. Ag ISEM 2□F	ge (In yrs. last b	irthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birthr	place (State or ntry)	Foreign
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	er de Items ner m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	)	13.	Was Decede If Yes, speci	ent of Hi fy Cubai	spanic Orig n, Mexican	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)	14	Black, White,		
36	irs aft	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	NO		1 Yes 2	No No	Specify:			s	pecify: Whit	:e	
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and	be fill hal H od oth	Be	17. Father's Name (First, Middle, Last	)							First, Middle, M				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.	우	Curtis A. Minor  19a. Informant's Name/Relationship	Time Print)	10	h Mailie	an Address				arl Cun			0-1-1	
<u>S</u>	d 2 s th an t7 ls r treur	6 0										23.4	Town, State, Zip		
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Baltimore,	Pages ent of nt: If I		1 ☐ Burial 2 🛣 Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Speci		Montgo	omer	y Cre	mato	rum,	0000		otho	sda, Ma	muland	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each l	d the death. Do									Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	Metasta	atic Les	sion	s In	the	Liver	-				Onset and D	eath
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K	ted sit	Examiner	cause. Enter Underlying Cause (Disease or injury	1955.25	a consequence	or).									
1.	and and	xar	that initiated events resulting in death) Last	c. Coagulo  Due to (or as	op <b>ath</b> a consequence	of):							_		
8760,	cate be executed physician and the burial-transit	Ical E		d											
9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit														
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal deat	h 3[	∃Ectopic pre	onancy				23	d. Date of delive		
	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown		5 🗆	Other (spe	city)					Month	Day Y	ear
P.0	at the ded by the a	Phy	9 Unknown			in the	-4-4-4		. 1. D. 41		One Distant				- 41- 0
ds,	ires tha signed I d be det	by	Part II. Other significant conditions				* -						e contribute to the No 3 Prob		
Ö	w requir been si should	etec	Diabetes, Ischem		уоратпу	, C	HEOHIC	2 00	struc	tive					
Records,	has be 2 s	Completed	pulmonary diseas	e							24a. Was ar autopsy perform	/	24b. Were auto prior to co death?	psy findings a mpletion of ca	valiable use of
		e Co	OF Man anno referred to medical								1□ Yes 2	<b>X</b> No	1 ☐ Yes	2 No	
Vital	/sicia	To Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \textbf{X} No	Hospital:	ent 2 ER/O	lutnation	 nt 3□ DO/	Othe			Check only one		Other (Specif	Prison	1
1 0	두 두 등		27. Manner of Death	28a. Date of Inju (Month, Da		Time of		c. Injury Work			d. Describe ho			)/IUI 1 [ B	агу
<u>o</u>	ath. r: After	atlo	1 Accident 5 Pending 2 Accident investigation		ay rear)	Injury	М		res 2□1	No					
Division		Certification;	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of in	jury - At home, f tc. (Specify)	farm, str	reet, factory,	office		28	Location (Str City or Town		Number or Rura	l Route Numb	per,
	ital or irs afte rel Dir led in		1												
	To the Hospital or within 24 hours affer To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	nysician: To the best miner: On the basis o and manner st	of examination a	ge, deatl ind/or in	h occurred a vestigation,	it the tim in my op	ne, date and pinion, deat	d place, and th occurred	d due to the ca at the time, da	use(s) ai ite and p	nd manner as s lace, and due to	tated. the cause(s)	
	o the o the comple	Med	29b. Signature and title of certifier	and manner si	iateu.		29c.	License	number		29	d. Date	signed (Month,	Day, Year)	
}	×   ×		1/10-	2	MA		TE	500							
	5		30. Name and address of person who	completed cause of	death (Item 23a)	) (Type:		588	Ι		F	epru	ary 16,	∠009	
			Isaias Tessema,					y. (	Cumber	rland	. Marvl	and	21502		
	Sta		31. Date filed (Month, Day, Year)	0.00	4 601			,, `			, -mar y 1		- Was Wife		
	Regist		FFR 1 7 2009	Benson	rar's Signature	Bark									
LUF	HMH 17 Rev 1/2	001	4 Green level												

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Certificate	of Death	Reg	. No. 2 U U 9	04545
	Physici	an	1. Decedent's Name (First, Middle, Last)	M			2. Date of Death Month	Day Year	3. Time of Death
200	/Medi	al	4a. Facility Name (If not institution, give street and number,	May	D Ab Ciby T	our all series of Death	9 1	3 200	1 8:15 AM
	Examir	ier	Holy Cross Hospital	,	46. City, 16	own, or Location of Death		4c. County of Deat	omery Co.
	Funeral		5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last bi	irthday) If Under 1 Months	1.	8. Date of Birth	9. Bird	hplace (State or Foreign
	Director		106-40-4514 10M 29F	61	Yrs.	Days Hours Will.	9-25-1		w York NY
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	Mary a-f sh	tor	MD PG	14	Va HESV	ille			1∭XYes 2 □ No
	or 28s	Direc	10e. Street and Number	1	10f. Zip 0	Code	10g	. Citizen of What Co	untry?
	ath wi	Funeral Director	3520 54th Avenue	-	2	0784		U.S.	A
	er de	nue	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decede If Yes, specif	nt of Hispanic Origin? (S fy Cuban, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
920	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the M-dical Evaria at rust be notified	þ	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates:	NO	1 □ Yes 2	No Specify:		Specify: Blo	acK
5-0	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual	Occupation done during most of work	16	b. Kind of Business/l	Industry
21215-0036	vithin ne. han "	mpl	Elementary/Secondary (0-12) College (1-4or s	5+)	life. DO NOT use	retired)		Sala	
	filed v Hygie other t		17. Father's Name (First, Middle, Last)		LUSTON		e (First, Middle, Mai	oute	
Maryland	ld be fental ked o	To Be	Jesse Mayo			Bott.	No.V	-/	
ary	should and Men is marke	-	19a. Informant's Name/Relationship (Type. Print)	198	o. Mailing Address (	Street and Number or Ru		XSC∕∕\ City or Town, State, Z	Zip Code)
	1 and 2 Health a em 27 is		Eunice D. Mayo Daugh	ter) 15	142 Pondho	. 0 11 1	Point NC.	27265	
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition		of Disposition (Name ery, crematory or oth	e of er place)	Date 200	c. Location - City or 7	Town, State
altimore,	- F # F		4 ☐ Donation 5 ☐ Other (Specify)	Kiverdale		2110119	2009 K	iverdale M	1D
Ba	permi Depar Impor any ir		21. Signatur of Funeral Service Licensee	·An	22. Name and	Address of Facility State Fun	eval Servi		bc 20011
			23a. Pert 1. Effer the disease, or complications that cause	the death. Do	not enter the mode				Approximate
المعاشد	Physician		Immediate Cause (Final disease or condition	ne.	Embolisa				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a consequence					Juddem
	_xummer	Ē	Sequentially list conditions, bb.	a consequence	+ailum	~			Days
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequenc	ory.				17.
Ö,	e exec ian an irial-tr		reculting in death) Leat	a consequence	of):				
68760	w requires that the death certificate be executed to be en signed by the attending physician and should be detached for use as the burial-transit	/Medical	d						
9 ×	certifi nding Ise as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy					
. Box	death	iciar	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 4 ☐ Pregnant a	2 ☐ Fetal death	3 Ectopic pre-			23d. Date of deliment	very Day Year
0	at the by th tache	Physician	9 ☐ Unknown						
Ś.	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions contributing to death by	ut not resulting ir	n the underlying cau	se given in Part I.	23e. Did tobace	co use contribute to	the cause of death?
Š	been :	eted	Milli Millians				1 Tes	2 No 3 Pro	obably 4 🕦 Unknown
Ř	has e 2	Completed	Multiple Myeloma				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
	an: T tifficat tor, pa	Be Co	25. Was case referred to medical			OC Disco of Death	1 □Yes 2 🛛		2 □No
O T O	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatie		utpatient 3 □ DOA	Other: 4 Nursing Ho	h (Check only one) ime 5 ☐ Residence	6 ∏Other (Spec	ify)
	ing P	ou:	27. Manner of Death 1 Natural 5 Pending (Month, Da (Month, Da)	ry 28b. 7	Time of 28c	. Injury at Work?	28d. Describe how in		,,
DIVISION	death ctor: , the f	icat	2 Accident investigation 3 Suicide 6 Could not be	uru. At hama fa	M M	1 □Yes 2 □No	001		
2	after after Direct	Certification: To	4 Homicide determined building, etc	c. (Specify)	rm, street, factory, o	mice	City or Town, Si	t and Number or Rur tate)	rai Route Number,
	lospit hours unera		29a. Certifier (Check only   Medical Examiner: On the basis of	of my knowledge	e, death occurred at	the time, date and place,	and due to the caus	e(s) and manner as	stated.
5	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director. After this certificate completely filled in by the funeral director, pag	Medical	one) and manner sta	ited.					
	<b>5</b> ≥ <b>6</b> 8		29b. Signature and title of certifier		29c. L	icense number	29d.	Date signed (Month,	, Day, Year)
		-	30 Name and address of person who completed cause of di	eath (Item 23a)	(Type Print)	32552		2/14/00	1
2			1500 Forest Clen Rd S	Silver-	Spring W	1) 20910-	1484		
	Stat	_	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	Town !				
	Registra		I ED T L COOL DENS	some for	KAR GERALES				l.

State of Maryland / Department of Health and Mental Hygiene For State Registra 14546 Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year J. Anita Martinez February /Medical 2009 09:30 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Hammonds Lane Center Brooklyn Park Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 218-44-1759 Director Feb. 26 1946 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1584 St. Margarets Road 21409 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Ş White Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatir 11 Dispatcher Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wright Robert Kina ပ Mildred Whittington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Smith (sister) 5419 Town Point Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. Date 13 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 2009 Baltimore, Maryland 21. Signature of Fune 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1 Enter the disease, or complic shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, us on each line. Approximate Interval Between Onset and Death LUNG Immediate Cause (Final **Physician** 9 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician; The law requires that the death certificate be Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy į Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perforn 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After t Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 ☐ Accident 5 Pending 4 hours after death. investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifica 29c. License number 29d. Date signed (Month, Day, Year) 129803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. ZIGER ,1406 S, CRAIN HWY. GLEN BURNIE STELOG M. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc 10e per fh 389 3-4-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Leila Padgett Moran 9, 2009 1700 February /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1900 1900 Stedwick Drive Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Director 214-34-7134 84 1924 Washington, DC April 11, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Evantings must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland | Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19000 Funeral 1900 Stedwick Drive 20886 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedo... Armed Forces? 1 ∏Yes 2 🛣 No 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>გ</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than amy Injury or other traumatic event, ID. M. once. Elementary/Secondary (0-12) College (1-4or 5+) Librarian Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Johnson Eliot Moran Louise Padgett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1534 Elwyn Avenue, Crofton, Maryland John Conant/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11, 2009 4 ☐ Donation 5 ☐ Other (Specify) Crematory Alexandria, Virginia 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature N Tuneral Service License . M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Ventricular Fibrillation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ending physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has I page 2 s performed? this certificate of Vital 1 ☐ Yes Hospital or Attending Physician: in 24 hours after death.

the Funeral Director; After this certific pletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1∭ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 □Yes 2 □ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0051280 February 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Suite 206, Rockville, MD Anushiravan Dadgar, D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

09-01132 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jude Nwaigwe State of Maryland / Department of Health and Mental Hygiene 2009 04548 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day February 7, 2009 Medical Examiner 1631 hrs Nwaigwe Ifeanyi 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Randallstown **Baltimore County** Northwest Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Min Hours Director 421-13-1215 Country) Nigeria 1X M 2 F 50 11 29 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Catonsville Baltimore MD Director 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? 21228 15 Forest Rock Ct. U.S.A. with t Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2X No within 72 hours after 3 Widowed 4 If Yes, Give Year Divorced Yes 2 X No specify: Specify. Black à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Self-Employed Limousine Service 12th grade 6yrs 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Grace Isaac Nwaiqwe Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m traumatic 2 Dorothy Nwaigwe-Wife 15 Forest Rock Ct., Catonsville, Md 21228 of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore
permit. Pages 1 a
Department of He
Important: If its
injury or other t crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3/14/09 Donation 5 Family Cemetery Amaimo, Nigeria Other Specify: gnature of Funeral Service Licensee 1 22. Name and Address of Facility March F/H West Tat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. grome Approximate Interval **Physician** Between Onset and /Medical Death a Biliary stasis with gastrointestinal ileus Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a, PII, 27, perME, G889 3/9/09 TT X UNPENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ģ σ. 1 Yes 2 No 3 Probably 4 ✔ Unknown CHronic renal failure; status post renal Completed Records, 24a. Was an 24b. Were autopsy findings available transplant autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 ✓ Yes 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other 4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other

Division of Vital within 2

he Hospital or Attending Physician: Thin 24 hours after death. He Funeral Director: After this certifica pletely filled in by the funeral director, pa

မ

Certification:

g

2

3

1 ✓ Yes

27. Manner of Death

Accident

Suicide

Homicide 29a. Certifier (Check only

29b. Signature and title of certifier

Ana Rubio MD.

1 X Natural

No

Pending

Investigation

State

31. Date filed (Month, Day, Year)

Assistant Medical Examiner 32. Registrar's Signatu

28a. Date of Injury (Month, Day, Year)

Registra

30. Name and address of person who completed cause of death (Item 23a)

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

28d. Describe how injury occurred

or Town, State)

28f. Location (Street and Number or Rural Route Number, City

February 8, 2009

29d. Date signed (Month, Day, Year)

54

DHMH 17 Rev 1/2001

State Registrar 9109

31. Date filed (Month, Day, Year)

Randallstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registra Signature

-1bert

2009

			State State Registrar	of Maryland / Depa	artment of F			ene g. No. 2009	04550
I	Physicia		1. Decedent's Name (First, Middle, Last)  YALE	NEMEI	RSON		2. Date of Death		3. Time of Death 8:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and BAYVIEW MEDICAL CENT	number)		r Location of Deat		4c. County of Death	
	Funeral Director		5. Social Security Number 126-22-9775 6. Sex 1 🖾 M 2 🗆 I	7. Age (In yrs. last birthday)	Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birth Cou	place (State or Foreign ntry) NY
	e Maryland 3a-f show	ctor	Usual Residence of Decedent	10c. City, Town or Lo	EW YORK				10d. Inside City Limits 1 X Yes 2 □ No
	h with th	al Dìre	10e. Street and Number  145 NASSAU STREET		10f. Zip Code	038	10	g. Citizen of What Cou USA	ntry?
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 22a or 28a-f show or other traumatic event, it is Medical Examinal must be rediffed at	by Funeral Director	Armed  1 □ Never Married 2 □ Married 1 □ Yes.	es 2 M/No	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
0-61717	within 72 hou iene. r than "natura it e Moles II	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  Colleg	ed) I (Give	edent's Usual Occup e kind of work done DO NOT use retired PHYSICI	during most of wo d)		6b. Kind of Business/lr	·
alia	uld be filed with Mental Hygiene arked other tha atic event, Itel	To Be C	17. Father's Name (First, Middle, Last)  JOSEPH	NEMERSON			me (First, Middle, Mi	aiden Surname) BAN	DES
, mary	and 2 should ealth and Mer n 27 is marke ner traumatic		19a. Informant's Name/Relationship (Type. Print) DAVID NEMERSON / SON	1				City or Town, State, Zi	•
illore,	permit, Pages 1 ar Department of Hee Important; If item any injury or othe once,		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Dispo cemetery, cre CARROLL 0				Oc. Location - City or T	
Dalithmor	permit. Pag Department Important; I any injury o		21/Signature of Funeral Service/Licensee		2. Name and Addre	ess of Facility	SOL LEVIN	SON & BROS PIKESVILLE	
	Physician /Medical		resulting in death)	at caus of the death. Do not en on each line.  CARDIAC ARREST to (or as a consequence of):		ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Beath Z
3	cate be executed by physician and the burial-transit and	dical Examiner	cause. Enter Underlying Cause Disease of Injury that initiated events  c.	to (or as a consequence of):					
O. Box 6	ding Physician: The law requires that the death certificate be executed h.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	hysician/Med	in the past 12 months?		☐ Ectopic pregnand	sy		23d. Date of deliver Month	very Day Year
ds, г.	uires that 1 n signed by id be deta	by P	Part II. Other significant conditions contributing ATRIAL FIBRILLATION	o death but not resulting in the u	underlying cause giv	ven in Part I.		acco use contribute to	.,
Vital Records,	The law req	Completed	PNEUMONIA				24a. Was an autopsy perform 1 🗆 Yes 2	prior to c	opsy findings available ompletion of cause of
VITA	ysician: s certifii director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital:	I X Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Oth	or.	ath (Check only one	nce 6 Other (Spec	ifv)
Ion or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification: To	27. Manner of Death 28a. D	Date of Injury 28b. Time of Injury Injury	of 28c. Inju Wor		28d. Describe how		
DIVISION	tal or Atte s after de al Directo ed in by th	Certific	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, farm, st uilding, etc. (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	ne Hospi n 24 hour ne Funer	edical	(Check only 2 Medical Examiner: On the	o the best of my knowledge, dea he basis of examination and/or i manner stated.					
<b>L</b>	To the Comp	Me	29b. Signature and title of certifier		29c. Licens	se number 087186	29	od. Date signed (Month)	
7	15		30. Name and address of person who completed DARLENE FUCHS-LYONS	cause of death (Item 23a) (Type	BAYVIEW	JOHNS HOF	PKINS - BA	ALTIMORE, M	ID 21224
	Sta Regist		31. Date filed (Month, Day, Year).	2. Registrar's Signature	1-17				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** NORWOOD 1212PM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND MEDICAL CN TIMORE Birthplace (State or Foreign Country) 6. Sex Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 / 27 / I 945 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 T F VA 218-42-1583 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Carrol1 Eldersburg 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 4607 London Bridge Rd. 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€€No 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify 2 Specify: 3 Widowed 4 Divorced white "natural" Completed er than "natura", the Medical B 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chesapeake Corp. 12 Quality Control Inspector 7 is marked other traumatic event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Ida Gibson Ray Adkins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Douglas Norwood/Husband 4607 London Bridge Rd., Eldersburg, MD 21784 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/17/2009 Cedar Hill Cemetery Baltimore, MD 4 □ Donation 5 ☐ Other (Specify) Funeral Service License 21. Signatu o <sup>22</sup>Burrier Queen Funeral Home & Crematory, P.A. Old Liberty Rd., Winfield, MD 21784 23a. Par 1. E fter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, str. ck, sr heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late ause (Final diseas of condition resulting in death) SEPSI **Physician** /Medical Due to (or as a consequence of): Examiner MULTIDRUG RESISTANT ACTIVETOBACTER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed Yes 2 certificate 2 No 1 □Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Xinpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 内Natura 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30 Nami

SUEST

31. Date filed (Month, Day, Year)

GREENE

ST BALTJIMORE

MD

ass of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year TERSON 0 BRUARY 06 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death SAMARITAN HOSPITAL BAL iMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2₹ F Months Days Hours Min. Yrs. 29 220-92-607 4-15-1979 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 U 4905 Harford Road SA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1€Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade N/A Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie McCov Charlene Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Brooks-Mother Balto, MD 21217 609 Gold Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial ACremation 3 ☐ Removal from State 2-13-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. MD 21202 North Avenue Balto, Land 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy performed? 2 XNo 1XYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√7No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner Box 68760, Ö σ. of Vital Records, Division

**Physician** 

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Certification: To

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State Registrar 29a. Certifier

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event.

**Physician** 

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or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral To the Hospital

MANISHA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Marvis

BAHL , MD

and manner stated

o Bar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5

29c. License number

D0058913

LOCH RAVEN

29d. Date signed (Month, Day, Year)
FEBRNARY
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04553 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2009 nae ebruar /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA Baltimore Memoria Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Davs | Hours | Min. | Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗗 F South 212-49-0106 Korea Director Jan 11 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or other traumatic event, the Midical Examiner must be notified at 1 Ves 2 No Director salti more 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 21218 USA ges 1 and 2 should be filed within 72 hours after death wint of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a treet Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 NO 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASIAM Specify þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) omesti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) INKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 21043 Informant's Name/Relationship (Type. Print) Ellicott Center Dr. #103, Ellicott City, fakdaughter ammie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 Surial 2 ☐ Cremation 3 ☐ Removal from State stlawn Cemelery Feb. 18,2009 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility 21. Signature of Funeral Service Licenses Howell Funeral Kd 20794 10220 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Has /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Box 68760,6 Due 16 nsequence of) the attending physician Physician/Medical the as nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) ☐Yes 2 No detached 9 Unknowr signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s certificate has autopsy perform 2 Di No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 N atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, 62. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore,

P.O. I

Division of Vital Records.

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			State Registrar  1. Decedent's Name (First, Middle, Last)	Ce	runcate or	Deam	2. Date of De	Reg. No.	3. Time of Death
	Physicia /Medic		Merlee Sylves	ter		kins Jr	Fabrua	N 10 th 20	109 550 P M
1	Examin	er	4a. Facility Name (If not institution, give street and number) Season's Hospice			or Location of Death		4c. County o	fDeath <b>timor</b> e
F	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 4 4 2 F	(In yrs. last birthday)	If Under 1 Year   Months Days		8. Date of Bit (Month, Da		Birthplace (State or Foreign Country)     MD
	σ		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evaninar must be neithed at	tor	MD Baltimore	•	rikesvil	1e			1 □Yes 2 No
	or 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	nat Country?
	sath w	Funeral	905 Dropleaf Ct.  11 Marital Status 12. Was Decedent E	ver in U.S. 13		1208 Hispanic Origin? (Sp	ecify Yes or No		S • A •
9	after d		11. Marital Status  1 ☑ Never Married 2 ☐ Married  Never Married 2 ☐ Married  Never Married 2 ☐ Married  If Yes, Give	0	If Yes, specify Cut  1 □Yes 2√□ No	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	Rican, etc.)		White, etc.
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ary	s 1 and 2 should I if Health and Men item 27 is marke other traumatic.	-	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Stree	t and Number or Rur		per, City or Town, S	itate, Zip Code)
e, N	ガモトド		Linda Gray-Friend  20a. Method of Disposition			f Ct., F	Pikesv Date		d 21208 Sity or Town, State
nor	ent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cre		i			
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.	J	s Mills, Md						
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not en		ash Ave			Approximate Interval Between Onset and Death
May.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Fm 51a	26 Park	insons	Disease			
	Examiner		Sequentially list conditions. b.						
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	a consequence of):					
o,	e executed an and rial-transit	1 —	that initiated events c.	a consequence of):					
9289	ficate be physicia s the buri	dical	d						
Box 6	eath certific attending p for use as f	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy				23d. Date	of delivery
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ds, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but PALLER FALLER		underlying cause gi	ven in Part I.			oute to the cause of death?
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l Re	The law ate has bage 2 s	gmo.	- POMETIVE DETAILS				auto perfi 1 □ Yes	opsy pr ormed? de	ior to completion of cause of eath? □Yes 2 □No
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Division	al or Attenders after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injubuliding, etc	iry - At home, farm, st <i>(Specify)</i>	treet, factory, office			(Street and Numbe wn, State)	r or Rural Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)  (Check only one)	examination and/or i					
	To th withir To th	Me	29b. Signature and title of certifier  Pull Lelliah Burlin		1-14	se number 593/		2/	(Month, Day, Year) 11/2009
6	TIV		30. Name and address of person who completed cause of d	eath (Item 23a) (Type	S Smit	h Avenu	= Bal	hmare 1	40 21208
	Sta		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature					
DH	Registi MH 17 Rev 1/2	_	FEB 1 7 2009 Amen A	. parkh					

amend #2 Per Phy g888 2/17/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Day Month **Physician** :35P<sup>M</sup> FEBRUARY ARTENTIOUS D. PILGRIM 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HAVEN NURSING HOME BALT IMORF 9 Birthplace (State or Foreign CATONSVILLE st birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M X F 213-30-5143 79 Yrs Director 12 25 29 SC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at 1 ☐Yes 2 XINo Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be ra 6002 Chesworth Road 21228 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🐉 ☐ No Specify Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2yrs Elementary/Secondary (0-12) 12th grade Claims Specialist Social Security Adm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be file nt of Health and Mental Hy i: If item 27 Is marked oth Be John Grice Dicey Belon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6002 Chesworth Road, Catonsville, Md 21228 Teresa Smith-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crestlawn 2/13/09 Marriottsville, Md 21. Signatur of Funeral Service Acenses 22. Name and Address of Facility March F/H West Monoson 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 2**□**√¶0 1 Yes 1 | Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Deat 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ar completely filled in by the fu death. 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Taymors Miller 9/39 MD D 4768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymona Millie Srule Renkstown Main 5 West 2/136 31 Date filed (Month, Day, Year) 32 Registrar's Signature State Backs Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	Otate of Ivial	ylaria / L	Certificate of I	Death		g. No. 2009	04556
Dhysisis		1. Decedent's Name (First, Middle, La					Date of Death     Month		3. Time of Death
Physicia /Medic		Eva		arker,		.,	February	9, 2009	7:20 P <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, gi	ve street and number)			Location of Death	1	4c. County of Deat	
Francis		Carriage Hill  5. Social Security Number 6.5	Sex 7. Age	(In yrs. last bir		hesda If Under 24 Hrs.	8. Date of Birth	Montgomer 9. Birt	hplace (State or Foreign
Funeral Director			1⊠M 2□F 89		Yrs. Months Days	Hours Min.	November 2	Year) Co	sachusetts
land ow		10a. State 10b. County		10c. City, Towr	n or Location				10d. Inside City Limits
Mary a-f sh	tor	Maryland Montgo	mery		Potomac				1 □Yes 2 No
or 28%	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
ath wi	ral	9520 Accord Drive	Т			854		United Sta	
er de	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 X Yes 2 ☐ No		13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
ours aft iral", or LEvami	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	MMII	1 □Yes 2 🔯 No	Specify:			hite
"natu	Completed	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of work	king 1	6b. Kind of Business/ Central In	telligence
withir iene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Se	enior Operat			Agency	
il Hyg other	Be C	17. Father's Name (First, Middle, Las	t)		-	18. Mother's Nam	ne (First, Middle, Ma	aiden Surname)	
uld be Ments Irked Itic ev	To E	Evan James Parker	r, Sr.			Zelma	Biddle		
2 sho and I s ma	•	19a. Informant's Name/Relationship			. Mailing Address (Street				'
l and Health		Evan James Parker  20a. Method of Disposition	r, III / So		20 Accord Di			ryland 208  Oc. Location - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Ergining must be notified at once.		1 ☐ Burial 2 Marcemation 3 E 4 ☐ Donation 5 ☐ Other (Speci			f Disposition (Name of ry, crematory or other place litan Crematory		uary	lexandria,	
permit. Depart Import any Inj once.		21. Signature of Funeral Service Lice	va-let	M01305	22. Name and Address Robert A. Pun 7557 Wisconsi	iphrey Fune	ral Home/Be	ethesda-Chev	y Chase, Inc.
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			eart Failure				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a						
LXammer	J.	Sequentially list conditions,	b. Cardio		ar Accident				
patr tisu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	oonsequence (	017.				
exect an and ial-tra	Еха	resulting in death) Last	c Due to (or as a	consequence	of):				
ate be nysicia he bur	Medical		d		-				
ertifica ling ph e as th	Med	IF FEMALE:							
death or e aftend d for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year
at the by th	hys	9 Unknown	9 🗆 Unknown						
res tha	by	Part II. Other significant conditions	contributing to death but	not resulting ir	n the underlying cause give	en in Part I.		acco use contribute to	the cause of death?  obably 4   Unknown
requi	sted								
has t	Completed						24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
n: Th ificate or, pag		25. Was case referred to medical				00 51 15	1 □Yes 2	XINo 1 □ Yes	2 🗆 No
/sicia s cert directo	o Be	examiner?	Hospital: 1 ☐ Inpatien	2 □ EB/Oι	utpatient 3 DOA Other	or:	th (Check only one	nce 6 □ Other (Spe	cifu)
ig Phy ter thi neral c	n:To	27. Manner of Death	28a. Date of Injury	28b.	Time of 28c. Injury Work		28d. Describe how		onyy
endin eath. or: Af he fur	atio	1 Natural 5 Pending 2 Accident investigation	on l	, , , , ,		Yes 2 □No			
affer de affer de l'Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, fa (Specify)	rm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ırai Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the afterding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C			examination an	e, death occurred at the tind nd/or investigation, in my o				
To the within To the Somple	Me	29b. Signature and title of certifier	11	1	29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)
		<b>)</b>	· M	, ),	ноо.	51280	F	ebruary 10	, 2009
gyti		30. Name and address of person who Anushiravan Dadga			(Type, Print) lecular Driv	ve, Suite	206, Roc	ckville, Ma	aryland 20850
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Carrel	-			
ricgisti	٠.	LEDTIS	UUU LAARAA	15.	169 64 SCO.				

			For State	State of Mary	•	partment of Fertificate of		, ,	iene g. No 2009	04557
6			Registrar  1. Decedent's Name (First, Middle, Las	rt)				2. Date of Deatl	h	3. Time of Death
	Physici /Medic		Edward		Pale	_ha_r	r Location of Death	Febrican	Day Year	
	Examin	er	4a. Facility Name (If not institution, give	ns Bayries	Center				C: The	Ralling
	Funeral		5. Social Security Number 6. S	ex 7. Age (/	In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign
¥.	Director		216-34-0724	<b>™</b> 2□ F	/1 Yrs	Months Days	Hours Min.		1000	ryland
	pu ,		Usual Residence of Decedent  10a, State 10b. County	110	0c. City, Town or	Location				10d. Inside City Limits
	shov shov	٦	Md.	"		imore Ci	tv			1√2Yes 2□No
	with the Maryland a or 28a-f show t be notified at	Director	10e. Street and Number		2410	10f. Zip Code	- /	10	Og. Citizen of What C	Country?
	ya or		2609 Fait Aver	1110		212	2/1		U.S.	Δ
	ms 2; mus	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 1	3. Was Decedent of h		ecify Yes or No-	14. Race - Am	erican Indian,
36	72 hours atter death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Fui	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	nican, etc.)	Black, Wh	White
9	72 hou	ted	15. Decedent's Ed (Specify only highest gra	lucation		ecedent's Usual Occup		dina	16b. Kind of Busines	s/Industry
21215-0036	- 4	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retire ine Elec	d)		Beth Ste	.a1
	e filed withir Il Hygiene. other than rent, the Me		12 th  17. Father's Name (First, Middle, Last,		Hai	THE BICE		e (First, Middle, N		(unk)
Maryland		B B	Edward J. Palo				Stella	•	naideir Surnaine)	(2227)
Z	2 should be f and Mental I is marked of raumatic eve	은	19a. Informant's Name/Relationship (		19b. M	ailing Address (Street	L		City or Town, State.	Zip Code)
≥ E	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Anthony Palche		272	7 Parall	el Path	Abingd	on, Mary	land21009
<u>6</u>	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla	ce)	Date :	20c. Location - City o	r Town, State
Saltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Hemoval from State		osary Ce	,	4-09 B	altimore	, Maryland
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer			22. Name and Addre	ess of Facility Ka	czorows	ki Funer	al Home, PA
8	8 8 <b>2</b> 6 8			dack, Ji.						Md.21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th one cause on each line.	e death. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pneu	imoi	nia				IZAYS
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	Obstru	7	Pola Na	Disease	VEAR
		ja l	Sequentially list conditions,	b. Due to (or as a c	onsequence of):	OBSIVE	ec/ive	THE	ey radic	/ /2///-3
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A.5 73	ESTE	2120				YEARS
oʻ.	exec an and rial-tra	Exa	resulting in death) Last	Due to (or as a c	consequence of		a . 1 .	-		HO WITHS
8760	cate be executed physician and the burial-transit	ical		d. Ven	11141	on De	pendo	n		7100115
9	ertifica ing ph e as tl	Med	IF FEMALE:							
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of d	elivery Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne or death	5 Other (specify)				
, P.O	ires that the de signed by the a i be detached i		Part II. Other significant conditions				ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
rds	quires n sign ald be	Completed by	Cerebro Vasa	cular a	cai do	2nT		1 X Y 6	es 2∐No 3∏F	Probably 4 □Unknown
000	aw requir s been si s should I	olete	ATMIGIL F.	brilla	Tion			24a. Was a		autopsy findings available
Ä	The lav	mo:	Diabéles	OZZIITA				autops perforr 1 Yes 2	ned? death?	completion of cause of s 2□ No
ita	sician: The certificate harector, page	Be C	25. Was case referred to medical examiner?			1933	26. Place of Dea	th (Check only on		
7	hysic this ce	은	1 ☐ Yes 2 No	Hospital: 1 Inpatient		ment 3 DOA		_	ence 6 Other (Sp	ecify)
'n	After Annerg	i.i	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Tim Inju	ry Wo	ryat rk? ]Yes 2∐No	28d. Describe ho	w injury occurred	
isio	death ctor: / the f	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 280 Place of injune	- At home, farm	, street, factory, office	1162 2 110	28f. Location (St	reet and Number or I	Rural Route Number
Division or Vital Records,	after Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,,,,		City or Towr	n, State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C		nysician: To the best of miner: On the basis of e and manner state	xamination and/o					
	omple	Mec	29b. Signature and title of certifier			29c. Licens	se number		9d. Date signed (Mo	
	F > F 0		1/135	ers to	)	DO	4383	. F	ebruary	11,2009
,			30. Name and address of person who							21224
4	x\ 1		William B. Gre	enough, II	I, M.D.	5505 Ho	pkins B	ayview	Circle F	Baltimore,M
i si si		ate	31. Date filed (Month, Day, Year)	32. Reg (strar)	s Signature	Barker				
	Regist	rar	FER 1	ZUUJ /		41	-			

DHMH 17 Rev 1/2001

09-01274 Kathleen Roach

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 04558

			For State			3. Time of Death							
edi	Physicia cal Examir	n/ 1	Decedent's Name (First, Middle,Last  Kathleen A. Road						Date of Dea Month February	12, 20	Year		0958 hrs
		4	a. Facility Name (If not institution, give	e street and number)	41	b. City, Town, or L Havre de Gr				н	County of arford		
an is	Funeral Director		6. Security Number 6. Sec. 16-15-9084	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days		24Hrs. Min.	8. Date of Bi				thplace (State or gn MD
	daryland 28a-f show any i at once.	1	Journal Residence of Decedent  Oa. State 10b. County  MD Harfor	d 10c. City, Tow		on e Grace							10d. Inside City Limits 1 Yes 2 No
	Marylan 28a-fs	Director	Oe. Street and Number			10f. Zip Code 210	78			10g. Citiz	zen of Wha	at Cou	intry?
	MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f show matic event, the Medical Examiner must be notified at once.	E -	523 Ha11 Ct  11. Marital Status 1 Never Married 2 X Married	1 Yes 2 No	If Ye	s Decedent of His es, specify Cuban	panic Origir , Mexican, I	n? ( Spe Puerto F	cify Yes or N Rican, etc.)			etc.	ican Indian, Black,
	rs after ural", o	<u>a</u>	3 Widowed 4 Divorced  15. Decedent's Education (Specify of	d If Yes, Give Year or Dates: only highest grade completed) 16	a Decedent	t's Usual Occupat	ion (Give ki	nd of wo	ork done		Kind of Bus		
!	5-0036 led within 72 hours after Hygiene. other than "natural", he Medical Examiner	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life.				Ar	emic	Ti	le & Marble
	Dre, MD 21215-0036 ss 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than her traumatic event, the Medica	ပ	17. Father's Name (First, Middle, Last	t)					(First, Middle Leisn		Surname)		
	21215-00 suld be filed wit Mental Hygien marked other ic event, the M	o Be	David A. Young  19a. Informant's Name/Relationship (			g Address (Stree	et and Numb	ber or R	ural Route N	umber, C			te, Zip Code)
J	ore, MD 2121 ss 1 and 2 should be fi st Health and Mental If item 27 is marked her traumatic event,	-1	Michael J. Roach	, Jr. (Husband)		all Ct		de	Grace				or Town, State
	Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus		20a. Method of Disposition 1 Burial 2 $X$ Cremation 3	Removal from State Rayry	matory or otl			02-	17-200			-	
	Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	+	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice	y	22. 1	Name and Addres	s of Facility	Sch	imunek	Fun	eral	Но	me of BelAir
	m  ឱ្ង≝្ទី l Physician		23a. Part I. Enter the disease, or com	pplications that caused the death. D	In o not enter t	the mode of dying	, such as ca	Pha ardiac or	respiratory	Bel_ arrest, sh	Alr,	MD art	Approximate Interval Between Onset and
	aminer		failure. List only one cause on a	Asphyxia by hanging  Due to (or as a consequence of):			Ŧ.						Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):									
	ted 1 insit	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):									
	760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED						Ta		C d a liv	
	Box 68760, c death certificate be ex the attending physician ed for use as the burial	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknow	23c. If yes, outcome of pregna  1 Live birth 4 Pregnant at time of deat	2 F	etal death 3 Other (Specify)	Ectopio	c pregna	ancy		3d. Date of Month	r deliv	Day Year
	D.O. B that the de ned by the detached:	y Ph	Part II. Other significant condition	s contributing to death but not res	ulting in the	underlying cause	given in Pa	art I.					to the cause of death?  robably 4 Unknown
	Cords, F law requires has been sign	pleted							pe	/as an utopsy erformed′ es 2 ✔	?	Were prior death	autopsy findings available to completion of cause of ? Yes 2 No
	tal Rec rian: The la certificate bector, page	ပို	25. Was case referred to medical			26.Pla	ce of Death					-	
	Wital Physician: r this certifi		examiner?  1 ✓ Yes 2 No  27. Manner of Death	28a Date of Injury	ER/Outpatier		Other <sub>4</sub>		ng Home 5 28d. Descr	ibe how i	injury occu		ther: Scene
	on of anding Plant.  After he funeral	tion:	1 Natural 5 Pending	FOUND:	FOUND: 0944 hrs	1	Yes 2 ✔	No	Subject h				
	jvisical or Atter der I Directo	Certification:	2 Accident Investig 3 Suicide 6 Could r	28e. Place of Injury - At hor			building, e	etc.	28f. Location or Tow 523 Hall c	on (Stree vn, State) court, Ha	t and Num arve de gr	ber or ace,	Rural Route Number, City
	Division of a to the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	ical Ce	29a. Certifier 1 Certifying Physical Exami	sician: To the best of my knowledgener:On the basis of examination an	e death occ	curred at the time.	date and p	lace, an	d due to the at the time, o	cause(s) date and	and mann	er as due t	stated. o the cause(s)
4	To t with To t	Medical	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse numbe			29		ned	(Month, Day, Year)
	1		30. Name and address of person w	ho completed cause of death (Item	23a)	enn Street, Ba	_	MD 2	1201				
	7	State	21 2 1 1 1 2 1 2 1 2	ssistant Medical Examiner  32 Registrar's Signatur		May 1	2, un 1101 G,	2		<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04559 State of Maryland / Department of Health and Mental Hygiene? [] [] 9 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 2009 Elizabeth Helen Reil 12:15AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 107 Riddle Drive Aberdeen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/27/1948 Birthplace (State or Foreign Country)
Kentucky 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 □ M 2 🖾 F Months Hours 59 220-52-6882 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner is ust be notified at 1 ☐ Yes 2 No Director MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 107 Riddle Drive 21001 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Elizabeth Nunner John William Ettinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Aberdeen Ave., Aberdeen, MD 21001 Dennis Custer Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/17/2009 | Hanover, Maryland Anatomy Gifts Registry 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive, Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 423 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending properties of the second 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1∐Yes 2. No signed by the Ö 9 Unknown 9 Unknown 9. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, b 1 des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 Yes 2 No 5 Nesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred at or Attending F after death. I Director: After d in by the funer Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 11\_ certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 32-600 2916109

State Registrar 31. Date filed (Month, Day, Year)

Year) 32 Registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kamprolen Muhan, mo 1106 Revolution St

32 Registrar's Signature

15

mo 21076

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04560 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8:10 PM 2 2009 Edward Ruggs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **ESSEX** Balto
9. Birthplace (State or Foreign Country) Riverview Care Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 10-4-1938 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**¥**□**Y**M 2□ F 70 Director 420-46-2125 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. m 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Counts 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be a collected at 1 Yes 2 □ No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21213 1100 N. Milton Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 ☐ No Black, White, etc. 1 □ Never Married 2 □ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes. Give Specify. ģ **X**₩idowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home improvement N/A 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Mitchell ဥ William Ruggs, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health Item 27 21213 1100 N. Milton MD Rhoda Ruggs-Daughter Avenue Balto, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 1 

Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer 2-17-2009 Balto, MD 4 Donation 5 Dother (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility March East F/H But Mill MD 21202 Balto, North Avenue 1101 Ε. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebra vasulos disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) attending physician for use as the hurial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 s 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt macre 32. Registrar's Signature 31. Date filed (Month State Registrar

nomas Rouleau		For State	St	ate o	f Maryland		artment of rtificate of		and	Menta	al Hy		Reg. No.	20	009	3 0	456
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Funeral Director		Social Security Nu 097.76.998	3	6. Sex		ge (In yrs. la	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of E			9. Birthp Foreign Coun	olace (Sta try)	te or NY
ow any	_		0b. County			10c. City,	Town or Location	on _									City Limits
the Maryland a or 28a-f show	101591	NY 0e. Street and Num	SCH0H nber	ARIR			GILBOA	10f. Zip Co	ode				10g. Citiz	zen of Wha			ZAANO
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Baltimore, permit. Pages I an Department of Hee Important: If ite	2	Burial 2 ) Donation 5 1. Sign = 1 - 4 - 1	Other S	pecify		aic	YVIEW CREI	. ,			FEB.	09, 200	)9 B	BALTIMO	ORE, N	1D	, ,
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Vital Recaysician: The this certificate I director, page		5. Was case referre examiner?  1. ✓ Yes 2		_	pital: 1 Inpatie	ent 2	ER/Outpatient		10	of Death (Cother		niy one) Home 5	Reside	nce 6 🗸	Other: S	Scene	
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Division of Bospital or Attending 1 24 hours after death. Funeral Director: Afte		Suicide Homicide	6 Coul	d not be mined	(Specify) Lo	cal Stree					M	8f. Location or Town, /est Main S	State) Street, E	ast of Ro	ute 31, \	Westmin	
To the Howithin 24 For the Funcompletely	٥	ne) 2 V	ledical Exa	miner: O ar	: To the best of m n the basis of exa nd manner stated.	y knowledg mination ar	ge, death occurr nd/or investigati	on, in my op	inion, d	death occu	e, and d urred at t	ue to the car the time, dat	use(s) and e and pla	d manner a	e to the o	ause(s)	
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カ ✓		0. Name and addres Ana Rubio M	D. Ass		Medical Exan	niner	111 Penn S	treet, Balt	timor	e, MD 2	1201						
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RIPPLE HAYNARD WSR

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			1 - For State Registrar	State of Ma	aryland / [		artment of ctificate of		nd Mental H	ygiene Reg. No. (	200	9 0	4562
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Las MAYNARD W. RIPPLE, SF	3.					2. Date of D Month	Day 12	Yea 3009	13	ne of Death
	Funeral Director		4a. Facility Name (If not institution, give  BALTIMORE WASHINGTON  5. Social Security Number  219,16,8494  Usual Residence of Decedent  10a. State  10b. County	MEDICAL CEN	e (In yrs. last bir	Yrs.	If Under 1 Yea Months Days	BURNIE		irth Day, Year)	ANNE ARU	INDEL irthplace (St. Country)  MD	de City Limits
	ith the Mar or 28a-f s	Director	MD ANNE ARUN 10e. Street and Number	IDEL	GLEN	BUR	NIE 10f. Zip Code			10g. Citiz	ren of What (		Yes ŽÄNo
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moderal Eventines must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Jyes 2 If Yes, Give Year or Dates:	No		210€ Vas Decedent of Yes, specify Cu	Hispanic Origi ban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)		USA  4. Race - Ar Black, Wr  Specify: W		n,
Maryland 21215-0036	within 72 ho ene. than "natur ne Modeal	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	(Give life. L	lent's Usual Occ kind of work don OO NOT use retir	e durina most o	of working		d of Busines	,	
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Baltimore,	iit. Pages 1 artment of H artant: If ite njury or ott		20a. Method of Disposition  1 X Surial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Funeral Service Cens			AYEN	sition (Name of natory or other pl	FE	Date B 17, 2009		ation - City o		e
Ba	Department of the permitted of the permi	ii 512	K. GREGORY F	INK MO	01148 the death. Do r	1		HWY. S.,	GLEN BURNIE		21061	Approxi	mate
	Physician /Medical Examiner	8 13	shock, or heart it ilur List only to immediat. Cause (Fina disease or a notition resulting in 1 th)	a	a consequence		dial	udque	900	200		Onset a	Between and Death
60,	be executed iician and burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	Ġ	OloJa	white	Pulmon	y S	Segs	2	
	the death certificate I by the attending physion sched for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗍 Fetal déath		Ectopic pregnar Other (specify)			23	3d. Date of d Month	elivery Day	Year
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f Vital	hysicia his certi I directo	To Be	25. Was case referre o medical examiner?  1 Yes 2 No	Hospital: 1	nt 2 🗆 ER/Ou	tpatien	3 DOA OI	har:	f Death (Check only ing Home 5 Res		□Other (Sp	ecify)	
Division of	or Attending Physician: ter death. Irector: After this certifics by the funeral director, p	Certification: To	27. Many r of Death 1 ✓ Natural 2 ☐ Accident  5 ☐ Pending investigation	28a. Date of Injur (Month, Day		ime of njury	28c. Inju Wo M 1	uryat urk? ]Yes 2.∏No	28d. Describe	how injury	occurred		
D			3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc					4	wn, State)			lumber,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one) 2   Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and	, death d/or inv	estigation, in my	opinion, death	place, and due to the occurred at the time	, date and p	olace, and du	e to the caus	
	<b>6</b> 8 8 8		29b. Signature and title of certifier	- 0	مع		D-	468	46	29d. Date	signed (Mon	blh, Day, Yea	7
11	) 🗸		30. Name and address of person who co	CHOL	r's Signature	Type, F	7S	RICH	is they,	64	SN t	Such MA	1661
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Elizabeth Zaporowski Rosenbrock 12,2009 7:30 AM February 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Belfir Health and Rehabilitation Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) Bel Ric If Under 1 Year | If Under 24 Hrs. Har Ford 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2K F 6, 1919 April Maryland 214-03-2035 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2 ☑ No Maryland Baltimore Phoenix 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 Brocster Court 21131 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Communication Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer Secretary 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Anthony Zaporowski Stephanie (nmn) Rydnski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan P. Edwards/ Niece 9 Brocster Court, Phoenix, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 2/16/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final d Stage disease or condition resulting in death) roew. Due to (or as a consequence of Sequentially list conditions Due to for as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐No 24a. Was an 1□ Yes 2 No

Physician /Medical Examiner

Department of H Important: If ite any injury or ot once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

2

**Funeral** 

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with

al Hygiene.

h and Mental H

Health em 27 i

3altimore, Maryland 21215-0036

attending physician and for use as the burial-tran signed by the a been si should I After this certificate has funeral director, page 2 To the Funeral Director: completely filled in by the

The law requires that the death certificate be executed

or Attending Physician:

hours after

within 24

20Senbrock

アストレートへ Division or Vital Records, P.O. Box 68760,

Completed by

State Registrar

Physician/Medical Examiner 25. Was case referred to medical examiner? Medical Certification: To Be 27. Manner of Death

1 Natural **∠** □ Accident 3∏ Suicide 4 Homicide

29b. Signature and title of certifier

1 ☐ Yes 2 No

29a, Certifie (Check only one) 5 ☐ Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient

and manner stated.

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

29c. License number

26. Place of Death (Check only one)

29d Date signed (Month, Day, Year)

en who completed cause of death (Item 23a) (Type, Print) 1308 Bususs

eler 32. Registrar's Signature 31. Date filed (Month, Day,

			For State Registrar	State of Ma	aryland		rtment of H tificate of L			ene 2009	04564
-	Physicia	an	1. Decedent's Name (First, Middle, Las						Date of Death     Month	Day Year	3. Time of Death
1	/Medic	al	Sarah 4a. Facility Name (If not institution, give	Pauline		Ro	OSE 4b. City, Town, or	Location of Death	February	Day Year 12, 2009 4c. County of Dea	
	Examin	er	13505 Fork Rd.	street and number)			Baldwin	Location of Death		Balti	
A Company	Funeral Director		212-01-4317	ex	e (In yrs. las 9		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV • 17,	9. Bir 1914 Mar	thplace (State or Foreign ountry) y land
1100	land bw It		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary a-f she ified a	ctor	Md. Bal	timore			Bald	win			1 □Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code	04.04.0	10	g. Citizen of What Co	
	eath v 1s 23a must	Funeral	13505 Fork Road	12. Was Decedent B	Ever in U.S.	. 13. \	Was Decedent of Hi	21013	ecify Yes or No-	USA 14. Race - Ame	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 1 N If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, <i>s</i> pecify Cuba l □ Yes 2 2 No	n, Mexican, Puerto	Rican, etc.)	Black, Whit	
50	72 ho 'natur dical I	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	lent's Usual Occupa kind of work done o OO NOT use retired	ation Juring most of worki	ing 1	6b. Kind of Business	•
121	filed within Hygiene. Ither than '	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	+)	lite. L	Cook	)		Calvert College Hi	
1d 2	e filed al Hygi other vent, t	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Name			<u> </u>
ylar	ould be a Mental narked o	To	Agos:		olla					riffilett	
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (*Patricia Rose/Daug				ng Address (Street a Box 1015			City or Town, State, and 21013	
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Pla		sition (Name of natory or other place			Oc. Location - City or	
ë E	Pages nent of I ant: If ite ury or o		1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 Ø ther (Specifi	2010	I -		Cemetery	1	5/09 Ba	ltimore,	Maryland
Baltimore, Maryland 21215-0036	permit. Departn Importa any inju		21. Signature of meral service do r	Buck	h		. Name and Addres	on Funera	wson, Ma il Home,	ryland 21 Inc. 105	204 O York Rd.
ř			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Bronc		-					week
	Examiner			Due to (or as	a conseque	ence or):					mon this
	# = #± •	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	ence of):					
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. 248 / A  Due to (or as a							years
68760,	ficate be executed physician and sthe burial-transit	edical E		d Demen	-	,					years.
	± 50 €	Medi	IF FEMALE:		-						0
P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal d	death 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions of					en in Part I.		_	o the cause of death?
COL	w requ	letec	COPD					· · · · · · · · · · · · · · · · · · ·	24a. Was an		utopsy findings available
Re	The lav	Completed	premia						autopsy perform	prior to	completion of cause of
/ita	clan; ertifica ector, p	BeC	25. Was case referred to medical examiner?	1124-1			- I au	26. Place of Death			
or	Physic rthis c	2	1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien	t 3 DOA Othe	4 LI Nursing Ho	me 5 Residen 28d. Describe hov	ce 6 Other (Spe	ecify)
on	nding tth. r: Afte e fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	Work	(?Î Yes 2 □ No		injuly occurred	
Division or Vital Records,	al or Atter s after dea Il Director d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju- building, etc		ne, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet a <i>nd Number or R</i> State)	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicían: To the best of niner: On the basis of and manner sta	examination	ledge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the vithing of the complete	Ž	29b. Signature and title of certifier				29c. License	number	29	d. Date signed (Mon	th, Day, Year)
			30. Name and address of erson who	des mo				31295		2/12/09	
	3 V		30. Name and address offerson who Wend! Klassz	completed cause of de	eath (Item 2 کمار	23a) (Type, - دیب ص	ed Ave	Ball .	mp 212	ی د	
	Sta		Wendy Klorsz 31. Date filed (Month, Day, Year) FEB 17 2009	32. Registra	ar's Signatu	refark	1		,		
	Registr	ar	FEB 1 7 2009	LERECE	10. 1	7					

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day William Ruddock 15,2009 9:47am Robert February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7901 Bon Air Road Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F Months Days Hours 212-48-1171 59 Director 04/11/1949 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits MD Baltimore Director Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a must b 7901 Bon Air Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Xyes 2 Marin If Yes, Give Year or Dates: Corps <sup>2□</sup>Marine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced "natural"; Completed Hygiene. other than "natur ent, the Medical B 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Insurance Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruddock James Margaret McConville ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Kay H. Ruddock / Wife 7901 Bon Air Road, Parkville, MD 21234 Important: if them any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 02/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 21. Signature of Funeral Service Licensee Porota Marshall 22. Name and Address of Facility Maryland Cremation Services Po Box 1413, Baltimore, MD 21203 1 Ohall 23a. Part1. Enter the disease, or complications that caused the deat and Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as I IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 perforn or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☑ No Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 XNatural Injury 5 Pending after death.

Director: Af
in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 104 2009 Minnie E11en Ridlev 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Season Hospice 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Days Hours 1 □ M 2 🛛 F 212-48-8291 June 14. 61 1947 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Md. Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 245 Walgrove Road 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 Grade College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Devaney Asbie Marie Henseley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown, Md. 21136 Lawrence E. Ridley Sr. 245 Walgrove Rd Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 2/13/09 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, Md. 21. Signature of Fundral Service 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral J. Wayne Osteding Home Reisterstown, 21136 23a. Part . Enter the disease shoot or heart failure. or conjugations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final End Stage Chronic Obstructive disease or condition resulting in death) Due to (or as + onsequence of): Sequentially list conditions, if any, leading to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 21. No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Espiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown poles Mollit 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No autopsy performed? /es 2 11 No Pulmonary
25. Was case referred to medical examiner? 1 ☐ Yes 26. Place of Death (Check only one) SPISOWS HOSPICE 6 DOther (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

23a or 28a-f show

items ;

5

'natural",

12 should be filed within 7 th and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau Pages 1 and 2

Director

Funeral

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Completed

traumatic event, the Medical Examinar must be notified at

filed within 72 hours after death

Saltimore, Maryland 21215-0036

been signed by the attending physician and should be detached for use as the burial-transit s certificate has the lirector, page 2 st

funeral director, After

Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

12 State Registrar

Physician/Medical 2 Completed Be Certification: To Medical

IF FEMALE:

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

23b. Was decedent pregnant in the past 12 months? 9 Unknown

> Other: 4 Nursing Home 5 Residence 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number

Avenue Baltimore

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Buton Deberah 31. Date filed (Month, Day, Year)

2835 Smith 32. Registrar's Signature

Barks

28b. Time of

			Please Type or Please Type of Please Type of Please Type of Please Type of Please Type or Please	rint in Blac TTME#8 Maryland7			Copies Are	e Legible. <sup>ne</sup> ว ก ก จ	04567
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of		Reg. I		3. Time of Death
	Physici /Medic		ALBERT EDWARD		MUEL	SR. T	etruar		
	Examir	ner	4a. Facility Name (If not institution, give street and numb	er)	BALT	IMORE	_ (	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 7. 212−34/-224/8 1 M 2 □ F	Age (In yrs. last t	birthday) If Under 1 Year  Yrs. Months Days	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, Yea	9. Bir	thplace (State or Foreign buntry) TH CARELING
	and wo		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location		7777	TIOTINUNC	10d. Inside City Limits
	e Maryl Ba-f sho	Director	MARYLAND N/A	E	BALTIMO	RE			1 Yes 2 No
	in30  ours after death with the Marylan rai", or items 23a or 28a-f show  Exemirer must be notified at	al Dire	10e. Street and Number  2901 RIGGS AVE	NUE	10f. Zip Code	216	10g.	Citizen of What Co	ountry?
	er death	Funeral	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S.	13. Was Decedent of H		ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
900	5-UU30 72 hours after death with the Maryland natural", or items 23a or 28a-f show dies Examinat must be notified at	ğ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date		1 □Yes 2 🕱 No	Specify:		Specify:	LACK
7	Z I Z I 3-0050 d within 72 hours aft gliene. er than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)		Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working d)	, 16b.	. Kind of Business	/Industry
Č	C C I C I		Elementary/Secondary (0-12)  College (1-4-  17. Father's Name (First, Middle, Last)	)r 5+)	LONGSHO	REMANU  18. Mother's Name (			M STEEL
<u> </u>	aryland should be f and Mental I s marked of umatic eve	To Be		MUE	2	SALLIE	riisi, Wildule, Wald	A	DUGLAS
Der			19a. Informant's Name/Relationship (Type. Print)  DAWN SAMUEL (DAV)		9b. Mailing Address <i>(Street</i>				
9	MOCE, IN Pages 1 and 2 nent of Health int: If item 27 iny or other tra		20a. Method of Disposition 1	20b. Place	of Disposition (Name of tery, crematory or other place	ce) Da	te 20c.	Location - City or	Town, State
	Dalitim permit. Pag Departmen Important: any Injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Wood1	XCO PHILL CEN	METERY 03/19/ ess of Facility			RE, MD
7		-	Va Die hichlich	Musin	2140 NI.FL		BALTIM	DORE, M	D 21217
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() 1	ed sit	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause)	ασ α συπσειματικ	e oi).				
	rebe executed sician and eburial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. — Due to (or	as a consequence	e of):		<del></del>		
- 1	tificate be e g physician as the buria	dical	d						
	<b>BOX 007</b> Jeath certificate attending physical for use as the leading physical for use and us	an/Me	IF FEMALE: 23b. Was decedent pregnant 1  Live bird	me of pregnancy	ath 3 Ectopic pregnance	ev		23d. Date of de	•
	the dea	Physician/Media		nt at time of death				Month	Day Year
9		ρ	Part II. Other significant conditions contributing to deat	h but not resulting	in the underlying cause giv	ven in Part I.			the cause of death?
	aw requ	Completed					24a. Was an	24b. Were au	utopsy findings available
<u> </u>	VII.al INEC Sician: The law scertificate has b irector, page 2 sl					· · · · · · · · · · · · · · · · · · ·	autopsy performed 1 Tes 2	? death?	completion of cause of
7	nding Physician: th. After this certifica funeral director,	To Be			Outpatient 3 DOA	26. Place of Death ( ner: 4 \sum Nursing Home		6 ☐ Other (Spe	ecity)
!	Attending Physician: The rebath. setor: After this certificate hey the funeral director, page	tion:	27. Manpor of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of (Month,	Injury 28b. Day, Year)	D. Time of lnjury 28c. Injury Wor	ry at 28 rk? ]Yes 2 □ No	d. Describe how in	ijury occurred	
	DIVISION OF VITAL DECORDS,  To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be of the property of the funeral director.	Certification: To	3 Suicide 6 Could not be 28e. Place of	Injury - At home, , etc. <i>(Specify)</i>	farm, street, factory, office		f. Location (Street City or Town, St.	and Number or Reate)	ural Route Number,
	ospital hours a uneral C		29a. Certifier 1 Certifying Physician: To the ba	est of my knowled	lge, death occurred at the ti	ime, date and place, ar	nd due to the cause	e(s) and manner a	s stated.
	o the H rithin 24 o the Fu omplete	Medical	(Check only one) 2 Medical Examiner: On the bas and manner 29b. Signature and title of certifier	stated.	and/or investigation, in my o			and place, and due  Date signed (Mont	
4	F 3 F 5		MANCOON M	D	120	4118	E	locator:	12 2009
	NV		30. Name and address of person who completed cause of K Tonua Mason GI	of death (Item 23a		tre Ro	Himny	Avos	W 21229
	Sta Registi		31. Date filed (Month, Day, Year) 32. Reg	Strar's Signature	1. barked				
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			For 1 _ State		State of Ma	ryland /					ental Hy	/gien	е		
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	Physicia	an	Do N			SIN	(- i r	Ton			2. Date of De Month	Da			Death 5 PM
	/Medic Examin				e street and number)	5110	0) [	4b. City, Town, o	or Location	of Death	FEBURA		County of Dea		.3 1
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	Funeral		<ol><li>Social Security N</li></ol>	lumber 6. S		(In yrs. last		If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bi	rth ay, Year	9. Bi	rthplace (State ountry)	or Foreign
	Director		212-40-4 Usual Residence of	700	LIVI ZAZII	67	Yrs.				SEP 19	194	I Mar	yland	
	yland now		10a. State	10b. County		10c. City, To	wn or Loc	ation		-	_			10d. Inside C	ity Limits
	a-fsh	ctor	MD	Anne Arı	ındel	Bro	oklyn	Park						1 □ Yes	2X No
	or 28	Directo	10e. Street and Nur		-110			10f. Zip Code <b>212</b> 2	)5			10g. C	itizen of What C		
	d within 72 hours after death with the Maryland glene. It than "natural", or items 23a or 28a-f show the Modical Exeminat must be indiffied at	Funeral		atta Aver	12. Was Decedent E	wer in II S	12 14	as Decedent of I		rigin? (Spo	oity Voc or N			SA	
0	riter d		<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li></ul>	ied 2□ Married	Armed Forces? 1 ☐ Yes 2 🛣 N		If	Yes, specity Cub	an, Mexica	n, Puerto F	Rican, etc.)		14. Race - Am Black, Whi		
215-0036	ours a	d by	3 Widowed	4 Divorced	If Yes, Give Year or Dates:		1	□Yes 2 <b>X</b> 1No	Specify	·:			Specify: W	nite	
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ק	e filed al Hyg other vent,	Be C	17. Father's Name	(First, Middle, Last)	)				18. Moth	er's Name	(First, Middle				
<u>Za</u>	should by and Ments s marked umatic e	To	Donald	Monroe	Hood				Lei	na ]	May	Janu	ary		
Maryland 21	2 ° - E			ame/Relationship (	**			Address (Street					,,		
	s 1 and of Health item 27 other to		JONN J.  20a. Method of Disp	Magness -	- son			gatta Av		•	ok⊥yn ate		ocation - City o	1225	
altimore,			1 ☐ Burial 2		Removal from State	Metro	Cres	ition (Name of atory or other pla <b>natory</b> ,	Inc.				ltimore		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Fu	neral Service Licer Steven	H. William	ns	22.	Crematic	ss of Sacil	iety	of Ma	ryla	nd, Inc	. 01 000	
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	/Medical		disease or condition resulting in death)		Due to (or as a			CENTA						UNIKA	nemn
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X Q Q	death cert e attending d for use a	sician/M	23b. Was deceden		23c. If yes, outcome of	2 Fetal dea		Ectopic pregnan	Су				23d. Date of de		Ye ar
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<b>7</b> .	law requires that the as been signed by the 2 should be detache	/ Phys	Part II. Other signif	ficant conditions	contributing to death bu	ıt not resulting	j in the und	derlying cause gi	ven in Part	l.	23e. Did	tobacco	use contribute t	o the cause of o	death?
g	quires an sign uld be	ed by	Ci	noncuy	artery	dis	easi	2			1 🗆	Yes 2	2 No 3 □ F	robably 4 🗆	Unknown
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0	Phys	٦.	1 ☐ Yes 2 ☐ 27. Manner of Deat		Hospital: Inpatie	nt 2 ER/	Outpatient o. Time of	3 LI DOA					6 ☐ Other (Sp	ecify)	
DIVISION OF	nding th. : Afte	tion	Natural 2 Accident	5 ☐ Pending investigation	(Month, Day	(, Year)	Injury	28c. Inju Wor M 1 E	rk? ]Yes 2.⊑		8d. Describe	now inju	iry occurred		
<u>                                      </u>	Atter	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place of Inju	ry - At home,	farm, stre				8f. Location	Street a	nd Number or F	ural Route Num	nber,
5	tal or rs afte al Dir led in	Certification:	4 - Hollicide		building, etc	. (Зреспу)					City or To	wn, Stat	'e)		
	To the Hospital or Attending Physician: The within 42 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	Certifying Ph 2 Medical Exar	nysician: To the best of miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the testigation, in my	ime, date a opinion, de	and place, a	and due to the ed at the time	cause( , date an	s) and manner and place, and du	as stated. e to the cause(s	s)
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			• Ule	runa	, RESID	TUS		R	ESC	000	1	Fris	URNRY	14,200	29
	2		30. Name and addr	ress of person who	completed cause of de VERMA  32. Registra	ath (Item 23a	a) (Type, P								
	Sta	te	31. Date filed (Mon	th, Day, Year)	32. Registra	ar's Signature	A A	arkal				. , .			
	Registr	ar		LFR ? (	COOR A	and le	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 2009 7:05 a M Luella Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Homewood Baltimore N/A 8. Date of Birth
(Month, Day, Year)
JUN 13 1931 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🛣 F 017-24-6180 77 Director **Massachusetts** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" ~ " any injury or other traumatic event and a specific process." 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 XYes 2 □ No Funeral Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 2704 N. Calvert Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Diefendorfer UNK ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Gray - friend 2706 N. Calvert Street, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2/17/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Spice Vene H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physiclan: The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Anter this certificate has been signifuneral director, page 2 should be v Completed by 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 🔯 Certifying PhysIclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2-16-09

State

Registrar

Year)

31. Date filed (Month, Day,

P.O. Box 68760;

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)?

CALILLAMO 1600 W. MOUNT Royal Are, Ballimore MD 2/2/7

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:10 PM 2009 hael Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Battimore i Year I If Under 24 Hrs. Bayview Medical Center NA Johns Hockins 5. Social Security Number If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 XM 2 ☐ F 245-94-8113 Director 5-2-1954 N.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprisive must be notified at Yes 2 No Director N/A Baltimore MD 10f. Zip Code 21213 10g. Citizen of What Country? USA 10e. Street and Number with 3431 Dudley Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black 9 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fraley & Schiling Elementary/Secondary (0-12) College (1-4or 5+) Welder Trucking N/A 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Anderson Smith Mable McGhee ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie H. Smith-Wife 3431 Dudley Avenue Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Cemetery 2-13-2009 Baltimore, 21. Signature of Fufferal Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stroke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physlcian: The law requires that the death certificate be executed Examir burial-transi erebro vasci Due to (or as a consequence of) physician the buria Division of Vital Records, P.O. Box 68760. Physician/Medical attending p for use as t IF FEMALE If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To after death. I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 1🗷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

) oseph Alex Kelamis

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

3026

32. Registrar's Signature

Baltimore, up 21224

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2:30 P.M Physician 16, 2009 Myrtice L. Sloman Feb. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale 1315 Chesaco Avenue Apt. 335 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-05-1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F Mississippi 88 265-18-1456 Director Usual Residence of Decedent 10c. City, Town or Location Rosedale within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State s 23a or 28a-f show Baltimore 1 ☐ Yes 2 No Md Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21237 1315 Chesaco Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. er than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 9th marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 Is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) Turner Lipsky Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33705 19a. Informant's Name/Relationship (Type. Print) 2343 South Shore Dr. St. Petersburg, Mr. Daniel Hall - Nephew Florida 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition Sacred Ht. Of Jes. 2-21-2009 Baltimore, Maryland 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liesinsee 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral 263 S. Conkling St. Balto. Md. Funeral Home 21224 23a. Part1. Enter th / disease, or shoot of Land failure. List Immedia. Cause (Final disease or condition resulting in death) omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. Onset and Death com **Physician** /Medical Examiner Sequentially list conditions, if any, leading to mini educate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregni in the past 12 months 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) □Yes 2 No P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an pate has I autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to m a a examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28d. Describe how injury occurred 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 A atural 1 ☐ Yes 2 ☐ No after death. 2 Accident Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospitai within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CPA ci fr (

DO08358

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** :15 P M ebruar 2009 /Medical dc. County of Death 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number) Examiner Daltimore moniun 8. Date of Birth (Month, Day, 24 Hrs. Min. (In yes. last birthday) Year If Unde 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1 □ M 2 🔽 F Months Hours Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits mportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 In No Director 10e. Street and Number 10f. Zi Code 10g. Citizen of What Country? 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Daltimore (D. Tolice Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) m ภาม 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Parkville eral Parkoil 8200 Harford rd. mp 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Ose to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) P.O. q | Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ s been signe should be c 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy To the Hospital or Attending Physician: The Vital 1 □Yes 1 ☐ Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HUSFICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this ð funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 29a. Certifier (Check only 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM MD 21093 2300 TONES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

BRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH S@888 12/273/2009 JTBepartment of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** KATHERINE February 2009 11:40 A.M PAGE SCHWABE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Roland Park Place 830 W. 40th. St. Baltimore 8. Date of Birth (Month, Pay, Year, Dec. 14, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F Dec. 1919 Minnesota 476-01-3791 89 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1X Yes 2 No **Funeral Director** N/A Maryland Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 830 W. 40th. Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify Completed by 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian 4 years Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Henry Page Amelia Steinmentz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5321 Woodlawn Avenue Chevy Chase, Maryland 20815
e of Disposition (Name of O2/20 ≠2009 | 20c. Location - City or Town, State Patricia Beverly (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Feb. 18,2009 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eleviery Due to (or as a consequence of): Sequentially list conditions Due to for as a nonsequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Be Completed by

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

show

ral", or items 23a or 28a-f shore Examiner must be notified at

"natural"

of Health and Mental Hygiene. If item 27 Is marked other than "natur or other traumatic event, Inc. Medical

signed by the a After this certificate has funeral director, page 2 s Medical Certification: To n 24 hours after death.

e Funeral Director: A
wetely filled in by the fu

9 🗌 Unknown		9 LJ Unknown							
Part II. Other signif	icant conditions o	contributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2[	use contribute to the cause of death?			
					24a. Was an autopsy performed? 1 □ Yes 2. ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No			
25. Was case refer	red to medical			ath (Check only one)					
examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3 ☐ [	Home 5 Residence	Home 5 Residence 6 Other (Specify)				
27. Manner of Deatl 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred			
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined			ome, farm, street, factory)	28f. Location (Street end Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one)		nysician: To the best of my kno niner: On the basis of examina and manner stated.				) and manner as stated. d place, and due to the cause(s)			

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

30. Name and address of pe

within 2

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. NoZ U 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 13, Žearos **Physician** RUSSELL LEONARD **SWARTZ** 7:20F M /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Medical Center OWSOR 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 3, 1931 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min **X**X M 2□ F Months Days Hours 215-28-3509 Director Maryland Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ital Macifical Examiner must be notified at 1 □Yes 2□No Director Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P 0 Box 392 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 X XIo Specify: If Yes, Give Year or Dates: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Engineering alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Leonard Swartz Sr Ella Marie Voshell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Woodham Swartz Wife P 0 Box 392 Phoenix Maryland 21131 Baltimore, 20a. Method of Disposition
1 ☑ Burial 🛣 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State GreenMount Crematory Feb 17,2009 Baltimore, Maryland M Donation 5 ☐ Other (Specify) 22. Name and Address of Facil Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Service Vicenses 6500 York Road Baltimore, Maryland 21212 MMG 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL DYSFUNCTION HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEVERE COAGULOPATHY HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and as the burial-transit be executed RHEUMATIC HEART DISEASE **60 YEARS** Due to (or as a consequence of) Box 68760, Physician/Medical that the death certificate as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2**X** No 1 Tes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 XNatural 5 Pending death. 1 □Yes 2 □No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide Hospital 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of cer 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who

MA 2009

Date filed (Month, Day

ompleted cause of death (Item 23a) (Type, Print)

76 VI DSI R 32. Registrar's Argnatur

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MARYLAND 21204

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Stancil Month **Physician** udith 4111 Feb /Medical Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medica IMOr if Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Days Director 215-56-5197 60 21, 1948 Jun. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1101 Oak Avenue 21085 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary <u>Medical</u> Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Layfette Stancill Melba Theodora Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 James Run Road, Aberdeen, Maryland, 21001 Evelyn Dale Gross / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gdn. 2/17/2009 5 ☐ Other (Specify) Aberdeen, Maryland 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home. P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or composition shock, or heart failure. List only of ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Abdomina /Medical Due to (or as a consequence of): Examiner Mesentenic Thrombosis Venous if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes Other: 2 No 1 🔄 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scaler MD #1144423112

29c. License number

29d. Date signed (Month, Day, Year)

22 S Greene St. Baltimore MD 21201

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	P.O. Box 68
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JOANNA	of Vital
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	For State Registrar	0.0.0 0.111		rtificate of l			. No. 2000	04576	
Physician	1. Decedent's Name (First, Middle,	Last)				Date of Death     Month	Day Year 14, 2009	3. Time of Death	
Physician /Medical	Joanna Tsig		Sola	4h Oit Tour a	Location of Death	February	10:09 P M		
Examiner	4a. Facility Name (If not institution, Stella Mari			Timonia		4c. County of Death  Baltimore			
Funeral		6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y July 26,		hplace (State or Foreign untry)	
Director	219–82–7897 Usual Residence of Decedent	1□ M 2½ F 5.	3 Yrs.			July 26,	1955   Gre	ece	
yland Now	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
e Mari	Virginia Fairfa	x	Falls Chu					1 ☐ Yes 2 ☐ No	
ther death with the Marylan ritems 23a or 28a-f show in at must be redified at Funeral Director	10e. Street and Number	D*1	202	10f. Zip Code 22041			g. Citizen of What Co USA	untry?	
ns 23	6137 Leesburg	Pike Apt.			lispanic Origin? (Span, Mexican, Puerto		14. Race - Ame		
J3(	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1	No	If Yes, specify Cuba 1 ☐ Yes 2 汉 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	hite	
completed by	15. Decedent' (Specify only highest		I (Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of worki		6b. Kind of Business/	Industry	
d 2121 filed within 7 Hygiene. other than ", ent, the Mix	Elementary/Secondary (0-12)	College (1-4or 5	5+) Manas		1)		Restauran	t	
nd 2 be filed tal Hyg d other event, Be C	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	(First, Middle, Ma	aiden Surname)		
ylar Menta arked attic er	Spiridon	Tsigarida			Ekateri		Zoura		
Maryland nd 2 should be file ath and Mental Hy 27 is marked oth r traumatic event	19a. Informant's Name/Relationsh		- 1	ng Address (Street Trescott			City or Town, State, 20		
Baltimore, Maryland 2 pernit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If flem 27 is marked other any injury or other traumatic event, Ill once.  To Be Co	Pedro Jorge Sola 20a. Method of Disposition	/ Husband_	20b. Place of Disponentery, cre				Oc. Location - City or		
Pages Pages Int: If i	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			trios Cem	6474	09 Ba	altimore,	Maryland	
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any Injury or othe	21. Signature of Funeral Personal	icense	2	2. Name and Addre	ss of Facility		1050 Yo	rk Road	
DO SOFES	· call	X. / and	Rt	uck Towso	n Funeral	Home, Ir	Towson,	Md. 21204 Approximate	
	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final				ig, such as caldiac	or respiratory arrow	,	Interval Between Onset and Death	
Physician / /Medical	disease or condition resulting in death)	_ a	TRAL CANCE a consequence of):	SK					
Examiner	Sequentially list conditions.	b							
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as	a consequence of):				10		
50, % be executed clan and urial-transit	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
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Box 6: leath certific attending F I for use as	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	cy		23d. Date of de Month	Day Year	
P.O. lat the de d by the etached	9 ☐ Unknown	9 Unknown							
be be be	Part II. Other significant condition	ns contributing to death b	out not resulting in the i	underlying cause giv	en in Part 1.			o the cause of death? robably 4 ื Unknown	
al Record  : The law requir cate has been s , page 2 should						24a. Was an autopsy	24b. Were as prior to death?	utopsy findings available completion of cause of	
al R  :: The iicate   i., page							X No 1 □Yes	s 2 □ No	
of Vital Rehysician: The land in certificate hard director, page 2	25. Was case referred to medical examiner?  1 ☐ Yes 2 ★ No	Hospital: 1 Inpati	ient 2 ☐ ER/Outpatio	ent 3 DOA Oth		h <i>(Check only one,</i> ome 5□ Resider		ecify) HOSPICE	
On of ding Phy After this funeral c	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Inj	urv 28b. Time			28d. Describe how			
Division of a tale or Attending Phys is after death.  Tal Director: After this led in by the funeral director of the control o	2 Accident investig	ation			]Yes 2□No	006 Leastion (Otro		und Boute Museley	
or At or At after d Direct lin by	4 Homicide determine	nod   Zoe. Place of in	jury - At home, farm, si tc. <i>(Specify)</i>	reet, ractory, office		City or Town,	eet and Number or R State)	urai Houte Number,	
Hospita Hospita 4 hours Funeral tely filled	29a. Certifier 1 Certifyin (Check only 2 Medical one) X Nurse Pra	g Physician: To the best Examiner: On the basis Control of the page of s	of examination and/or i	ath occurred at the t investigation, in my	ime, date and place opinion, death occur	, and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
To the within 2 To the comple	29b. Signature and title of certifier		CPA	29c. Licens		29	d. Date signed (Mon		
	Jenny	. Hay	WIP		7629		2/16/20	09	
12	30. Name and address of erson				<b>ТТМОХІТІ</b> Т	( Mm olo	03		
> State	JENNIFER HAUF, 31. Date tiled (Month, DayYear)-		DULANEY VA	-	THUMLUF	1, MD 210	<i>,</i> ,,		
Registrar	FER 1 7 2009	Dinseral	A. park						

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Examiner

Physician/Medical

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Completed

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Medical Certification: To

	Please	Type or Prin								.egible.		
For State Registrar		State of Ma	aryiand / L	•	tificate			vientai Hy		009	045	77
1. Decedent's Name		<sub>ast)</sub> ouise Sta	mey				2. Date of De Month	Day	Year 2009	3. Time of		
4a. Facility Name (I	f not institution, g	ive street and number)			4b. City, To	wn, or Loc	ation of Death	)	4c. C	ounty of Deat		
FRANKLI	n Squ	are Host	1TAL Ce	nTer		_	dale		13	aLTIL	nov e	) No.
5. Social Security N 217-01-	umber 6.	Sex 7. Age 1 □ M 2 🖾 F	e (In yrs. last bir	thday)	If Under 1 Months D		Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, D Sept.	rth ay, Year) 10,19	9. Birt Co	hplace (State o untry) VA	r Foreign
Usual Residence of	Decedent											
10a. State	10b. County		10c. City, Town	n or Loca	ation						10d. Inside Cit	y Limits
MD	Balt	imore	E	sse	sex						1 □Yes	<b>¾</b> [∏No
10e. Street and Nur	mber				10f. Zip Code				10g. Citizen of What Country?			
100 Ann	Avenu	e				2122	21		Ţ	JSA		
11. Marital Status 1 □ Never Marri 3X Widowed	ed 2 Married	12. Was Decedent Armed Forces? 1		lf.					Black, White	American Indian, White, etc. White		
15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give						done durin	g most of wor	king	16b. Kind of Business/Industry			
Elementary/Seco	ndary (0-12)	College (1-4or 5	+) C	ler	O NOT use <b>k</b>	retired)			Balt	imore	City	Hosp
17. Father's Name	(First, Middle, Las	st)				18.	Mother's Nan	ne (First, Middle	e, Maiden S	urname)		
John W	lalter '	Revnolds					Marv	Elaine	⊃ Gil	den		

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Cemetery M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funerat Service License 300 Mace Ave. Balto.MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, ercom shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Immediate Cause (Final disease or condition resulting in death)

/son

Approximate Interval Between Onset and Death

Year

20c. Location - City or Town, State

Baltimore MD

**Physician** /Medical Examiner

physician and s the burial-trans

attending p

signed by the a d be detached for

certificate has been sirector, page 2 should

: After this certific funeral director, I

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

item 27 i

permit. Pages 1
Department of F
Important: If ite
any Injury or ot
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other

Stamet

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease of righty that initiated events resulting in death) Last

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

Lawrence J. Braun Jr.

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:5-	Due to (or as a consequen of):
o	
	Due to (or as a consequence of):
).	
	Due to (or as a consequence of):
1	

IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2. ZNo Month Day 5 Other (specify)

9 Unknown

9 Unknown

23e. Did tobacco use contribute to the cause of death?

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

100 Ann Avenue Baltimroe MD 21221

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

1 ☐ Yes

2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 🔲 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Injury

26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 28d. Describe how injury occurred

autopsy

1 □Yes 2 □No

27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide

investigation 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Authou 32. Registrar's Signature 31. Date filed (Month, Day; Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Bon Secours Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year) | 05-06-1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖁 F MD Yrs 219-22-3202 81 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21223 30 N. Bentalou Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates S Q <sup>Specify:</sup>African American 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bennett Warehouse Laborer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Royal Robert Woodley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 N. Bentalou Street Baltimore, MD 21223 Mattie Satterfield -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02-18-2009 Baltimore, MD Mt. Zion 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complimations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day filled in by the funeral director, page 2 should be detached been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying came given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 | Inpatient 2 | EB/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Fafter death. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital of within 24 hours at To the Funeral D Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

AMBACHEN 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Velma Gladys Sanders 5 45 AM FEB /Medical 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore AGNES Baltimore City MOSP ITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗙 F 91 217-01-5996 **Director** Maryland 01/14/1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c, City, Town or Location show 10d. Inside City Limits ns 23a or 28a-f shor must be notified at Director MD 1 ☐ Yes 2X No Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Benson Ave Funeral United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: white 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) 10 College (1-4or 5+) Clerical State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Whipp Gladys Corum 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Craig R. Sanders / son 2802 Herkimer Street Baltimore, Maryland 21230 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 Removal from State Loudon Park Cemetery 02/12/2009 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signatu e of Fundr 1328 Sulphur Spring Rd Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYPOXIC RESPIRATORY disease or condition resulting in death) 2 DAYS /Medical Due to (or as a consequence of): Examiner BILATERAL PNEUMOTHORAX 4-5 DAYS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death signed by the at d be detached fo 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HYPOTHYROIDISM 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled Hospital 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOSPITAL

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#18perFH. G888.2/17/09 WS
State of Maryland / Department of Health and Mental Hygiene 04580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZO W **Physician** Year STERNIN IRINA 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE JEWISH CONVALESCENT & NURSING If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country RUSSIA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth **Funeral** 1□M 2XF Days Hours Min. 1472771926 219-23-5096 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the "Mulical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 USA Completed by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 □Yes 2X No Specify. 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. **TEACHER** EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) Peysner
TEUSNER 17. Father's Name (First, Middle, Last) Be LIPIN MORDECHAI ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 CHERRY MANOR CT., ROSA ZUMER / DAUGHTER REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 02/16/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. TUC 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** colli Gm /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, but in a termination cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Mp the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): 68760, the attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) detached o 9 Unknown 9 Unknown Division of Vital Records, P. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performs certificate 1 □Yes 2 200 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XINo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No hours after death filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Registrar

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32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15, Doris Newnam Sweeney February 2009 10:00AM M /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner 13019 Evanston Street Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 X F Months Days Hours Min 238-24-6339 Director 85 November 30, 1923 North Carolina Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No 28a-f Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3 13019 Evanston Street 20853 United States death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ∏Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ٥, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William T. Newnam မ Kathryn T. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Sweeney/ Husband 13019 Evanston Street, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date February 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park | 19, 2009 4 Donation 5 Dother (Specify) Rockville, Maryland Name and Address of Facility Robert A. Fumphrey Funeral Tome/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Y<u>ears</u> Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 14 hours after clearh sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be Abdominal Aortic Aneurysm 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \( \overline{\Delta} \) No certificate 1 ☐ Yes 2 🗆 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🙆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25818 February 16, 2009 30. Name and address of person who onpleted cause of death (Item 23a) (Type, Print) Sean M. Dwyer, M.D. 5454 Wisconsin Avenue#925, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney 04582 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Narendar Nath Soni February 11 2009 11:33 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months -Days Hours 81 Director 093-32-4994 March 10, 1927 India Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Myclical Eventual 23a any Bijury or other traumatic event, the Myclical Eventual 23a ang New 250 and 25 and 6028 Berkshire Drive 20814 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>\$</u> Specify: Asian-Indian 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ram Rakha Mal Soni Saraswati Devi ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda F. Soni/Wife 6028 Berkshire Drive, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State February 4 □ Donation 5 □ Other (Specify) 2009 Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature of Funeral Service License Bamkon M01546 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sentic Physician /Medical Due to (or as a c Examiner nemon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 2 No 2. No Division of Vital 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 066066 30. Name and address of person pleted cause of death (Item 23a) (Type, Print) Wone 8600 Old Georgetown Road, Bethesda, Maryland 20814 32. Registrar's Signature 31. Date filed (Monthy Day; -Year) State Registrar

oni, Narendor.

Amend #21 per FD G888 2/17/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 045

		1 - For State Registrar		Otate	or ivia	yland / D	Certific	cate of	Death		Reg. No.	201	19	04583	
Physic		1. Decedent's Nar  Mary Si	ne (First, Middle, L <b>mpson</b>	ast)						2. Date of De Month  Januar	Day	2°	009	3. Time of Death 6:30 A M	
/Medi Exami		4a. Facility Name	(If not institution, g	ive street and nu	ımber)		4b.	City, Town, o	r Location of Dea	th		ounty of D			
Funeral Director		5. Social Security 177–16–3	Number 6.	Sex 1□M 2 <b>X</b> F	7. Age	(In yrs. last birth		nder 1 Year oths Days			th	T q		ice (State or Foreign y) <b>unknown</b>	
faryland show ed at	'n	Usual Residence of	of Decedent 10b. County			10c. City, Town							10	d. Inside City Limits 1 □ Yes 2 No	
with the A a or 28a-1 be notifi	Direct	10e. Street and No				Middi	Le Riv	. Zip Code			10g. Citizen of What Country?				
ire, INIATYIANG Z1Z15-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene Item Z7 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Ma	ndlass D:  rried 2□ Married 4□ Divorced	12. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	orces? 2 <b>X</b> No ive			21220 Decedent of F specify Cub	lispanic Origin? (\$ an, Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)	/es or No- (etc.) 14. Race - Americ Black, White, Specity:		/hite, et	c.	
Maryland 21215-UU36 tid 2 should be filed within 72 hours aft th and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exami	Completed		15. Decedent's lecify only highest g	Education	)		l Decedent's (Give kind o life. DO No	Usual Occup of work done OT use retire	nation during most of wo d)	orking	16b. Kind	White . Kind of Business/Industry			
DG Z 12 e filed with all Hygiene other tha vent, the l	Be Com	unknown	(First, Middle, Las				cnown		18. Mother's Na	me (First, Middle	unkno , Maiden S				
arylan should be ind Mental in marked o	To	unknown				1			unknown						
e, Mar 1 and 2 sh Health and tem 27 ls rr other traum		Mr. Wei	Name/Relationship nkam	(Type. Print)		10	002 F1	ailing Address (Street and Number or Rural Route Number, City or Town, S  72 Frederick Rd. Catonsville, MD 2						Code)	
baltimore, permit. Pages 1 ar Department of Hea Important: if item; any injury or other once.			sposition : Tremation 3 5 Other (Spec		State			Disposition (Name of crematory or other place)  Date  20c. Location - City or Town, State  1/25/2009  Baltimore, MD							
ermit. Pepartr nports ny Inju			uneral Service Lic	ss of Facility eral Hom	е 2829 Н	udson	Stre	eet							
htificate be executed rational groups of physician and as the burial-transit	ledical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Coronary Artery Disease  Due to (or as a consequence of):  Complete Heart Block  Due to [or as a consequence of]:  Complete Heart Block  Due to [or as a consequence of]:  Hypertension  Due to (or as a consequence of):  Hypertension  Due to (or as a consequence of):  Hypertension  Due to (or as a consequence of):													
death cel	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								23d. Date of delivery  Month Day					
_ c p #	ed by Phys	Part II. Other sign	Ificant conditions	contributing to o	death but	not resulting in	the underly	ing cause giv	en in Part I.					cause of death?	
The la ate has page 2	Completed									24a. Was auto perfo 1□ Yes		24b. Were prior death 1 □ Y	to com	sy findings available pletion of cause of	
ysician ysician is certifi director	o Be	25. Was case reference examiner? 1 ☐ Yes 2▼	erred to medical	Hospital:	Inpatien	t 2 ☐ ER/Outp	patient of	TDOA Oth	26. Place of De er: 4 Nursing I	ath (Check only o		D0:bc= (0	manit 1		
ending Pheath.	Certification: To	27. Manner of Dec  1 X Natural  2 \( \text{ Accident} \)  3 \( \text{ Suicide} \)  4 \( \text{ Homicide} \)	ath 5 ☐ Pending investigati 6 ☐ Could not	28a. Date (Moi	of Injury	28b. Ti	ime of ijury M	28c. Inju Woi 1 □	y at k? Yes 2 □ No	28d. Describe  28f. Location ( City or To	how injury Street and	occurred		Route Number,	
Hospita 4 hours Funeral tely filled	Medical C	29a. Certifier (Check only one)	1 XCertifying F 2 Medical Ex	aminer: On the I	e best of basis of e	examination and	death occu	rred at the ti ation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) a date and p	nd manner place, and o	as sta	ted. he cause(s)	
To the within 2 To the comple	Me	29b. Signature an	d title of certifier	e le c	Tul	k m	1. D-	29c. Licens	e number 7188		29d. Date		onth, D	ay, Year)	
(( ))			dress of person wh			, , ,		Dans 3 - 7	l. MD 01	222					
SI	ate	31. Date filed AMO		2.		's Signature			K, MU 21	LLL					
Regis		FE	B 17200	9 Sens	3-12	1. 1	arks	'							

			For State	State of Maryla	and / Depa		lealth and M	lental Hygi	ene200	
			Registrar	1)	Cei	tilicate of t	Dealii	2. Date of Death	g. No.	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Las					Month	Day Ye	ar
	/Medic		William Edwin Tol			Ab City Town or	r Location of Death	February	15, 2009 4c. County of D	
	Examin	er	4a. Facility Name (If not institution, give						,	
			Broadmead Retirements Social Security Number 6. Se		yrs. last birthday)	COCISE If Under 1 Year_	CYSVIIIC If Under 24 Hrs.	8. Date of Birth	Baltimo	DIE COUNTY Birthplace (State of Foreign
	Funeral Director			C71.4 - C7 -	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec . 14,	Year) 1932 Ba	Country)
			Usual Residence of Decedent							
	yland		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	a-f st	ctor	Maryland Baltimo	re County (	Cockeysv	ille				1 □Yes 2 ☑ No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show digal Eval. I wit for noithed at		13801 York Road	unit E12		2:	1030		United	States
	dear	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.1	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, /hite, etc.
O	after or it		1 Never Married 2 Married	1 Yes 2 No		1 □Yes 2∑ No	Specify:		Specify:	White
Š	ours iral",	d by	3 Widowed 4 Divorced	Year or Dates:Peac						
21213-U39	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	I (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worki	ng	16b. Kind of Busine	-
٧	vithin ane. than	립	Elementary/Secondary (0-12)	College (1-4or 5+)		Self Emp			Southern	
7	Hygie Hygie ther	ပိ	12   17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	<u>Service</u> faiden Surname)	r_IIC.
Ĭ	l be f intal l ed of ed of	Be	Edwin Toland				Alpha Bai	, ,		
	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (	Type Print) (	19h Mailir	ng Address (Street	and Number or Rura		City or Town. Sta	te. Zip Code)
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mydfoal Ever, I'm Could be applied a once.		Mrs.Adrienne (nee	(44777)		York Roa				∍,MD. 21030
บั	is 1 and 2 and Health a item 27 is		20a. Method of Disposition			sition (Name of matory or other place			20c. Location - City	
2	ages int of t: If it		1 ☐ Burial 2 ☒️Cremation 3 ☐	Removal from State		natory or other plac eral Char	, reb.	17,	Doscout II:	III Maraaralaa J
saumore, maryiand	artme artan ortan injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen			2. Name and Addre		9 ! .	rorest n.	ill, Maryland
ם מ	Depar Impo any Ir once	l	12th un -	f. Jan	// Pe		lternátiva	es Funer	al&Cremat Maryland	tion Ctr.,P.A.
			23a. Pa 17. Enter the disease or company of k, or heart failur s. List only	plications to caused the d	leath. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
,	Physician		Immediate Cause (Final	one caus on each the.	Muse	lacent	ic lev	Lemi	5	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cons		way	10 100	WILL	0	1 was
	Examiner				U	U				
		je.	Sequentially list conditions if any, leading to immediate	Due to (of as a cons	sequence of).					
	executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
Ď	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a con:	sequence of):					
	ate b hysic he bu	lical		, d						
200	death certificate e attending phys d for use as the	Physician/Medic	IF FEMALE:							
ROX	ath ce ttend or use	au/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	Fetal death 3	Ectopic pregnanc	су		23d. Date of Month	f delivery Day Year
5	e deg	Sici	1 ☐Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify) _				
Ţ.	d by etach	F.	Part II. Other significant conditions of	entributing to death but not	reculting in the u	nderlying cause div	en in Part I	23e. Did toh	acco use contribu	te to the cause of death?
or vital Records,	The law requires that the de ate has been signed by the bage 2 should be detached	þ	CADD	ontributing to death but not	Toolking in the d			1 □ Ye		Probably 4 ☐ Unknown
5	requi	Completed	D	1.12						
် ပ	2 2	nple	Kenal	taller	$\mathcal{O}_{}$			24a. Was ai autops perforn	y prio	re autopsy findings available r to completion of cause of
=	: The cate h	ပွဲ							1 🗆	Yes 2 □No
711	ding Physician: The th. Ster this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		T OH	26. Place of Death			
0	Physical this call direction	မ	1 Yes 2 No	I   Inpatient	2 ER/Outpatie	nt 3 🗆 DOA	4 LA Nursing Ho		ence 6 Other	Specify)
	ling I After funer	<u>ö</u>	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Yea	r) Injury	Wor	rk? ]Yes 2□No	Zou. Describe no	w injury occurred	
S	tend leath tor: the t	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e 200 Place of Injury /	At home form et		1462 2 1140	28f Location /St	reet and Number of	or Rural Route Number,
DIVISION	or Attending after death. Director: After in by the funer	Certification: To	4 ☐ Homicide determined	building, etc. (Sp	pecify)	reet, lactory, office		City or Town		n rigidi riodic Numbei,
_	pital Surs surs eral		29a. Certifier 1 Certifying Ph	nysician: To the best of my	knowledge, deal	th occurred at the t	ime, date and place.	and due to the c	ause(s) and mann	er as stated.
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medical Examone)	miner: On the basis of exar and manner stated.	mination and/or i	nvestigation, in my	opinion, death occur	red at the time, d	ate and place, and	due to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Me	29b. Signature and title of certifier		1.	29c. Licens	se number	2	9d. Date signed (A	Nonth, Day, Year)
			Box IM.	" (ALLA	4/7/	汉) 7	7282	92	2/11	12000
	CX		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)		10	110	
1	g5x1		BARRARA CA	PROIL.M		3801 V	ORK R	3D.	COCK F.	VSVILLE, MT
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regietrar's S		1		- /	1	,
	Regist		FFR 1 7 2009	Consider &	9. park					
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DHMH 17 Rev 1/2001

Amend #5 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 04585 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2009 **Physician** 0420 AM 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NIF Agnes Hospita Bautimore 5. Social Security Number 6798 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Carolina 6. Sex 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Year) 1 □ M 2 🛂 🗲 Months Days Hours Min 243-36-6190 80 Yrs. 0 Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examination ust be notified at th ma 1 Nes 2 No Director Kandallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 WOO sveen Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black Completed by Specify: 3 ☐ Widowed 4 ☑ vorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) omes tomemaker Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KDU iram 19a. In o mant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Balto. Weldon MD 21211 LOVY 10C0 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Deurial 2 ☐ Cremation 3 Removal from State 19,2009 Baltimore 4 Donation 5 Dother (Specify) Feb. 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Funeral Howel Home 21207 Hants 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). law requires that the death certificate be executed B physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Torre Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy Dicease perform 201 2 No 1 ☐ Yes or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Certification: To 1 ☐ Yes 2 👿 No 1 npatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Pesidence} \) Residence \( 6 \) Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Medical 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature apotitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054258 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 BALTIMORE HOSPITAL 900 CATON AV M. SHARMA AGNES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2009 Registrar

## Baltimore, Maryland 21215-0036

Box 68760. physician P.O. Records, Division of Vital

Amend 19a, per Fh g888 2/17/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04586 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 200 9:45 PM 02 David Hughes Tilley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City n/a Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours June 16,1920 **Director** 215-12-8919 88 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 V No Directo West Friendship Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 12450 Barnard Way Funeral Pages 1 and 2 should be filed within 72 hours after death or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∰Yes 2 ☐ No 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify 2 Specify: 3 X Widowed 4 □ Divorced "natural" White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) th and Mental Hygien 7 is marked other th 12 04 Corporation Executive Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Ε. **Tilley** Mary Josephine Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and 2 D partment of Health Important: If item 27 i any Injury or other tra John M. <del>tilley</del>/Son 15549 Carroll Road, Monkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 2/16/09 Marriottsville, MD 21. Signature of Funera Service Livensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21 Michael 23a. Part 1. Enter the disease, or marrications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final PHEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 weeks HYPOXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 □Yes 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation illed in by the fi 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of pertifier AT2438946 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMEE Memorial Hospital MD Union 31. Date filed (Month,-Day; Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 0621 Marian J. Tiernev /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saltimore, Mi Inder 1 Year | If Under 24 Hrs. | St. Adnes N/A Hospital 8. Date of Birth (Month, Day, Year)
Apr. 15, 1 7. Age (In vrs last hirthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 □ M 2 F Hours Min 213-34-9945 71 1937 Director West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

In proportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modell Experiment stat be netfined at once. 1 ☐ Yes 2 TXNo **Funeral Director** MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 First Avenue, Apt. 311 21227 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 █ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Price Fisher Nellie Whitehair ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas D. Tierney - Husband 200 First Avenue, Apt. 311, Lansdowne, MD 21227 20b. Place of Disposition (Name of Crestlawn Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17-2009 5 Other (Specify) Marriottsville, MD Gardens 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Road, Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Months Immediate Cause (Final METASTATIC Physician LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for es a consecuence ori: Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No performed? 1 ☐ Yes 2 ANo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) D16354

Registrar

State

900 CATON AVE BALTIMORE MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST AGNES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04589 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day Year Mildred Benson Tobin February 2009 13. 7:05PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5555 Friendship Boulevard #731 Chevy Chase Montgomery 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛱 F Months Days Hours Min. Director 80 579-40-5103 August 15, 1928 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Wedcal Evantion of the resulted at 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 □ No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5555 Friendship Boulevard #731 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or iter 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify Be Completed by 3 ₩ Widowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence Benson Helen Dick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen M. Tobin/ Daughter 4601 45th Street, N.W. Washington, D.C. 20016 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State February 16, 2009 permit. Page Department o Important: If any injury or once. injury or Crematorium, Inc. 16, 2009 | Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 755/ Wisconsin Avenue
M00335 | Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Brain Aneurysm 5 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical **∤F FEMALE** 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 ☐ Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Lung Cancer 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary Embolism certificate has autonsy performed? Yes 2 No 1 □ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1∐Yes 2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 □Yes 2 □ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier MD32156 wasn February 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

3301 New Mexico Avenue N.W Washington D.C. 20016

Thomas, M.D.

32. Registrar's Signature

Kristin E. 31. Date filed (Month, Day, Year)

FFR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 10, 2009 **Physician** 10:20 pm R. Uhlia Jane /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Brighton Gardens Baltimore 8. Date of Birth (Month, Day, Year) March 27, 1913 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 □ M 2 🗓 F 95 212-01-1317 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d, Inside City Limits 10b. County show ir than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 XNo Baltimore Baltimore Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21212 6451 N.Charles St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify: White Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Healer/ Teacher Elementary/Secondary (0-12) College (1-4or 5+) Spiritual Awareness permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 Is marked other this any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smucker Emma J. Rutt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1469 Blue Mount Rd. Monkton, Md. 21111 Susan Dollenger/ Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Co. 2-14-09 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician af OFEMENT IA 1 FARS COMPLICATIONS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Rother (Specify) NOSPLIA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation f Dabiatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

31. Date filed (Month, Day, Year) Registrar

NOWA

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

5-

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTERP of MENVIL 76 1 Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 04591 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year vane1< 12:50 DM Febroary 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kandallstown Battimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **X** X 2 □ F Days Hours Min 972372 Year) 218-18-6706 87 Yrs Director Czechosiovakia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Fedical Examinat must be notified at Baltimore Baltimore Md. 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature."

any injury or other traumatic accessory. 21207 USA 3706 Buckingham Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No WW2 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 M Married 1 □Yes 2 No White Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Specify. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
2 Years Elementary/Secondary (0-12) Years Supervisor Construction 17. Father's Name (First, Middle, Last)

Vanek
Frank
Vanek
Sr. 18. Mother's Name (First, Middle, Maiden Surname) Be Sik Anna ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanek Vanek (Wife) 3706 Buckingham Road Baltimore, Md. 21207 Ruth W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 14, 09 Pikesville, Druid Ridge Cem. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home J. Wayne Osterlina Reisterstown, Md. 21136 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or hear failure. List only one cause on each line. 23a. Part 1. Enter Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only orfe) Other: 4 Nursing Home 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 K ER/Outpatient 3 □ DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral! 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0055644 10, 2009 Februar 124 address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 5401 Old Coort

Year,

31. Date filed (Month, Day,

Randallstown

32. Registrar's Signature

21133

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene N4592 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Charles Rodney Wesley 8:44 P M February 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) July 13, 1945 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours Min. **¼**□M 2□F 63 385**-**44-7286 Michigan Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1044**-**J Spa Road 21403 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Mayes 2 No 1971 If Yes, Give Year or Dates: 1973 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Wesley Jean Colpus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Lynn Wesley, Wife 1044-J Spa Road Annapolis, Maryland 21403

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

GINGHIC

Due to (or as a consequence of)

Metro Crematory Inc.

**Physician** /Medical Examiner

Physician

**Examiner** 

10a. State

Director

Funeral

2

Completed

Be

မ

20a. Method of Disposition

Immediate Cause (Final

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

21. Sighaure J. Funeral Service Ocease
Thomas Gregor

**Funeral** 

Director

/Medical

disease or condition resulting in death)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical δ Completed Be

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 900 exastatic Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I., 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death Natural Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signal and title of certifie 29c. License number

State

Registrar

bert 31. Date filed (Month, Day, Year)

30. Name

medical 32. Registrar's Signature

daddress of person who completed cause of death (Item 23a) (Type, Print)

20c. Location - City or Town, State

23d. Date of delivery

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

Baltimore, Maryland

02/16/09

22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228

amend #10e Per FH G888 2/23/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 18:25 PM 00 Februar 10.2009 /Medical ac. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** 6. Sex If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 🔀 M 2 🗆 F Days Hours 57 JUL. 13, 1951 MD Director 214-56-5706 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 X Yes 2 □ No Director BALTIMORE MD et and Number 10f. Zip-Code 10g. Citizen of What Country? 10e. Street 1608 USA 21213 Funeral <del>1208</del> E. CHASE ST death items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOME IMPROVEMENT SELF EMPLOYED 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be JESSE L. WRIGHT MARY B. RICHARDSON မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NAOMI EPKINS 1208 E. CHASE ST., BALTIMORE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 Cremation 2-20-09 OWERS Mill torest 4 Donation 5 Other (Specify) Son 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licenses Nes 2007-09 EASTERN AVE., BALTIMORE, MD caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest n each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure ist only one cause Immediate Cause (Final **Physician** disease or condition resulting in death) MRNS PULMONMY /Medical (or as a consequence of) **Examiner** DATIC DISSECTION Sequentially list conditions, if any, leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events Day to for as a nonsequents of HYPERTENSION physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 5 Other (specify) 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be d Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 TYes 2 🗌 No death. 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title 29d. Date signed (Month. Dav. Year) License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW STOUBACH 600 North Wolfe St, Baltimore, MD, 21287 parker egistrar's Signatur 31. Date filed (Mont State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04594 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FERVERE **Physician** Trines Webbert 5:00 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Oak Crest Village Baltimore 8. Date of Birth (Month, Day, Year) 1921 Sept. 19, 1921 Mary land 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 213-12-6997 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, I'm McIcal Exercises: 101 be retified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2XXNo Director Md. Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 Walther Blvd. Apt.2102 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify ð WWII 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merle Webbert Eleanor Becker ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Webbert/Son 15425 Falls Road Sparks, Maryland 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/18/09 Garrison Forest Owings Mills, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-stage **Physician** demen 3 44/3 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Stentals 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

7 2009

Isbomb whow chut 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

3900

32. Registrar's Signatur

R110361

Lock Raven Blvd Baltimore

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item	State of Maryla 8 per fh, g	and / Dep 03/03/06	artment of H 5/09dhb rtificate of L	lealth and M D <i>eath</i>	lental Hyg	iene eg. No. 200	04595
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н	Physici /Medio		Olive	B. W	allace			Month Februar	v 12. 2009	5:30 A M
and a	Examir		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death	r cor arr	4c. County of Dea	
	0		Gilchrist			Tows	son		Baltim	ore
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		thplace (State or Foreign ountry)
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	and		Usual Residence of Decedent  10a. State 10b. County	100.	City, Town or Lo	cation				10d. Inside City Limits
	f sho	ō	,							1 □Yes 2 ☑ No
	28a-	ect	Maryland Baltimor	e	Phoeni	X 10f. Zip Code		140	0= 0 4	41
	with with	<u></u>		1			104		0g. Citizen of What Co	ountry?
	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show digal Exn. ibwr must be notified at	Completed by Funeral Director	3738 Dance Mill Ro	DAQ . Was Decedent Ever in	ILS 13	211	-	cify Vas or No-	U.S.A.	vican Indian
(0	r iter	돌	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 ☑No	10.0.	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto I	Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	urs a	Ş	3 Widowed 4 □ Divorced	If Yes, Give 🔨 Year or Dates:		1⊡Yes 2XINo	Specify:		Specify:	White
Õ	2 hor	ted	15. Decedent's Educa	tion	16a. Dece	dent's Usual Occupa	ation	- 1	l 16b. Kind of Business	
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	Mer Mer arke	2	Moody	Baker				Laura	Pierson	
ar	2 sho and is ma auma		19a. Informant's Name/Relationship (Type	. Print)	19b. Mailir	ng Address (Street a	and Number or Rura	l Route Number,	City or Town, State,	Zip Code)
	and 2 Health Im 27 her tra		Kathy W. Murdzak	Daughter	3738	Dance Mil	1 Road	Phoenix	, Maryland	21131
w w	es 1 of H <b>fiter</b> roth	1 3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	20h	p. Place of Dispo cemetery, crer	sition (Name of natory or other place	D:		20c. Location - City or	
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Y F	Physician	8.1	Immediate Cause (Final disease or condition		ATON	S FRAM	HID ON	417100	4	Onset and Death
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Θ	ng pl	Med	IF FEMALE:					will the	1101	
O. Box	death certifi e attending p d for use as	Physician/Me	23b. Was decedent pregnant 23c	If yes, outcome of preg		Ectopic pregnancy	(m	17-7	23d. Date of del	ivery
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Division of Vital Records,	stan:	Bec	25. Was case referred to medical				26. Place of Death			2 No _
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0 2	fter th	٦	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?		8d. Describe how		sily) (100) CCZ
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SIN S	er de recto	<b>≌</b>	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office	28	Bf. Location (Stre	eet and Number or Ru	ral Route Number,
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9			29a. Certifier  (Check only 2 Medical Examine)	ian: To the best of my k	nowledge, death	occurred at the time	e, date and place, a	nd due to the car	use(s) and manner as	stated
9	in 24	Medical	one)	and manner stated.		resilgation, in my op	eath occurre	d at the time, dat	te and place, and due	to the cause(s)
Ē	To To	≥	29b. Signature and title of certifier			29c. License		296	d. Date signed (Month	n, Day, Year)
				110		D64	1395	F	EBRUANU I	2, 2009
1		İ	30. Name and address of person who comp	leted cause of death (It	em 23a) (Type, F	Print)			TE, MA 2	
2	✓		DANIEUE DO BERMAN, N. 31. Date filed (Month, Day, Year) FEB 1 7 2009	13 6565 N C.	HAPLES SI	, SUITE 20	19	BALTIM	TE, MA 2	1204
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04596 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** 2009 Harold. Wade, Sr. 16 7:55 a M J. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Towson If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 XM 2 ☐ F Months Days 95 216-05-0050 May 20, 1913 Maryland Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 1 ☐ Yes 2√ No Director Towson Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 615 Chestnut Ave. #1222 21204 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Section Chief 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Frances William F. Wade ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 Sechrist Flat Rd. Felton, Pa. 17322 Mr. David Wade/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 2-19-09 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Funeral Service Ucensee 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final wears **Physician** mont disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached for 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 1 □ Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year)

February 16, 2009 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bolto MI 21202 pe, Print). Chalo. 670 GAMC a. la 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	Dog	strar ecedent's Name (First, Middle,Last							2.	Date of Death Month D	ay Year		3. Time of 1401 I	
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		Facility Name (if not institution, give	street and nu	mber)		4b. City, Tov Baltimo		cation of L	Death		N/			
		University Hospital		7. Age (In yrs. la	ast hirthday)	If Under		If Under 2	24Hrs. 8	Date of Birth	(MM/DD/YYYY)	g. Birth	place (Sta	ite or
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exau		. Father's Name (First, Middle, Last		yrs.		51001				First, Middle, M	aiden Surname			
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, MD 21215-0036 and 2 should-be filed within 72 hours after death with the Maryland teath and Maryland statist and Maryland Hygière. traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19	la. Informant's Name/Relationship (	Type, Print )		19b. Mai	ling Address	(Street	and Numl	ber or Ru	ral Route Num	ber, City or Tow	n, State	, Zip Code .1108	•)
MD d 2 sho lith and m 27 is		Mr. Robert C. Wi	eber /	Husband	. Place of Disp				. M1	Date	ille, M	- City or		ate
Te, Fand I and Healt Fitem	20	Da. Method of Disposition  Burial 2 X Cremation 3	Removal	from State	crematory or	other place)			0/1/					
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Healtman In Important: If item 27 is injury pr other traumatic	4	Donation 5 Other Specif	/:	At	lantic			_		12009	Glen Funeral			
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Division of Vital Records, pital or Attending Physician: The law require ours after death.  Then Director: After this certificate has been sifilled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could determ	not be		at home, ram	, 0000, 1001	,,,			or Town,	State)			
ie on iii		4 Homicide	1.7		vledge, death	occurred at t	he time,	date and p	place, an	d due to the ca	use(s) and man	ner as s	tated.	a(e)
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying Phy one) 2 Medical Exam	iner:On the ba	sis of examination	on and/or inve	estigation, in r	my opini	on, death	occurred	at the time, dat	e and pidoe, an			(5)
To COL	Me	29b. Signature and title of certifier	_arra manii			2		nse numbe	er		29d. Date s			y, 1 Gar/
		anetz					0.0	C.M.E.			1 entual	, 10, 2		
		30. Name and address of person v	ho completed	cause of death	(Item 23a)	enn Street	Baltir	nore M	D 2120	)1				
0 1		41	21	cal Examiner		ani Sueet	,							
St	ate	31. Date filed (Monte Pay, Year)	2009	Denewa	A	back	1							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** \_P M 7:32 Lee Wessel February 10. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year)
Jan. 22,1969 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🙀 F 40 MD Director 212-15-2420 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 X Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1455 Dartmouth Ave. Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Ant: If item 27 Is marked other than "natural", or items 233 USA 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ş Specify: 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Agent Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Chapman <u>Evelyn Clarke</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Wessel Husband 1455 Dartmouth Ave., Baltimore, Md. 21234 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ite
any injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2/12/09 Cremation Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Bal Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Scatic shack
Due to (or as a consequence of) one week /Medical Examiner one week Sequentially list conditions, respiratory distress syndrome cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed that initiated events resulting in death) Last Streptococcus group A toxic shock syndrome bne week Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

★XYes 2□No 24a. Was an autopsy performed? Y□ Yes 2 □ No r Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 24 hours after death. e Funeral Director: After 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29b. Signature and title, of certifier 29d. Date signed (Month, Day, Year) Lavard L Siegel 19

State Registrar

DHMH 17 Rev 1/2001

A. faces **ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Howard L. Siegel, M.D.

31. Date filed (Month, Day, Year)

D28885

6701 N. Charles Street Baltimore, MD 21204

2/11/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #26 Per Phy G888 2/17/09 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year Feb. 6;15 AM 12, **Physician** Madelyn S. Weber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson 318 Dunkirk Ave. 9. Birthplace (State or Foreign 7 Country Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 219-22-8486 6. Sex 8. Date of Birth **Funeral** ADri Pay 21 Days Hours Months 1927 1 □ M 2 XF Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Adoil Evan." Arbutus Maryland Baltimore 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21227 1159 Linden Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 □Yes 2 No 3altimore, Maryland 21215-0036 Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Insurance Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Aargadon Phillip Sperlein ပ္ 195 Maring Address (Street and Number of Rival Royte Number City 21072 7 late, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Henry R. Weber, husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 20c. Location - City or Town, State Date 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-16-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address funeral Home, Inc. Signature of Funeral Service Licenses 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UV. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, pe Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2,1 1 ☐ Yes 2 🗆 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Other: 4 Nursing Home State idence Wother (Specify) residence examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 27. Manuar of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 □Yes To the Hospital or Attendii within 24 hours after death, To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check or one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) buerne ww 31. Date filed (Month, Day, registrar's Signa State ack Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 11 2009 **JOSEPH** DAVID WEINER 4:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ASBURY - SOLOMONS ISLAND SOLOMONS ISLAND CALVERT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 03/04/1916 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Months 1 X M 2 □ F 92 Yrs. 217-36-9128 MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 28a-f show Examiner must be notified at **CALVERT** 1 □Yes 2 No Director MD SOLOMONS ISLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 11100 ASBURY CIRCLE, #325 20688 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "r any injury or other traumatic event, the Med once. than, College (1-4or 5+) 5+ Elementary/Secondary (0-12) ATTORNEY AT LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WEINER SARAH ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IRTA WEINER / WIFE 11100 ASBURY CIR., #325, SOLOMONS ISLAND, MD 20688 20b. Place of Disposition (Name of BETH HAMEDROSHer place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HĀĠÖDÖL CŎNĞREGATION 02/13/2009 ROSEDALE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Melt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renol Physician Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 12 ertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician ar s the burial-t Due to (or as a consequence of): Completed by Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 22 No 24a. Was an autopsy performed? 1□ Yes 212(No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 42Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 PrNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Division or Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Medical and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital Rd Prince Frederick MD MI 110

31. Date filed (Month Day, Year) 32. Registrar's Signature

MN

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of I	Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	lealth a D <i>eath</i>	and Mental H	ygiené Reg. No		046	01
			1. Decedent's Name (First, Midd	fle, Last)					2. Date of I	Death Da	v Year	3. Time of I	
	Physicia /Medic		Kenneth	Wilhelm					Febru	ary	14, 2009	9 2:25	a <sup>M</sup>
	Examin		4a. Facility Name (If not institution	on, give street and numb	er)		4b. City, Town, or		4c.	4c. County of Death			
			Seasons Hosp  5. Social Security Number		Age (In yrs.	last hirthday)	Randal If Under 1 Year			Birth	Baltimore  9. Birthplace (State or Foreign		
	Funeral Director		216-01-2275	1 🔀 M 2 🗆 F	93	Vro	Months Days	Hours		Day, Year)	1915 Maryland		
		l ⊦	Usual Residence of Decedent							.,			112
	arylar show	i. I	10a. State 10b. County	,		y, Town or Lo Randal						10d. Inside Cit	,
	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dieal Evaninet must be notified at	Director	MD Ba	ltimore	r	Kanuar.	10f. Zip Code			10g Cit	tizen of What Co		
	with t			. Dun Dood			211	33		109.01	U.S.A.		
	ns 23	Funeral	4010 Falls	12. Was Decede	ent Ever in U.	S. 13.			gin? (Specify Ye's or l	No-	14. Race - Ame	rican Indian,	
9	or iter		1 ☐ Never Married 2 ☐ Ma	Armed Force 1 Yes 2 If Yes, Give	No No		ryes, specify Cuba 1 ⊡Yes 2 ⊠d No		i, Puerto Hican, etc.)		Black, White	e, etc.	
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lary	es 1 and 2 should be filed within of Health and Mental Hygiene. I tiem 27 Is marked other than ir other traumatic event, ITE M.		19a. Informant's Name/Relation	and Numbe	er or Rural Route Nur	nber, City o	or Town, State, 2	Zip Code)					
Σ,	and 2 lealth m 27 her tr		Jane S. Ramon	Daught				y No	rth Eastha				
altimore, Maryland 21215-0036	Pages 1 nent of H int: If ite		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 ☐ Removal from Sta	ate c	emetery, cřei	sition (Name of natory or other plac				ocation - City or		
ţ	it. Par rtmen rtant: njury		4 Donation 5 Other (		Dru		dge Cemet		2/18/09 911824 Red		esville,		
Bal	permit. Page Department Important: It any Injury o		21. Signature of Funeral Service	e Licensee	12.				ome Reist			21136	
		7	23a. Part/1. Enter the disease.	or complications that cau	ised the death						J. 112	Approximate Interval Bety	<del>)</del>
	Physician	1	shock, or heart failure. Lis diate Cause (Final			00 500						Onset and D	eath
	/Medical		disease or condition resulting in death)		as a consequ		Conce						
	Examiner		Sequentially list conditions	b	_								
9	∕p ∺	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	uence of):					9		
1/20	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	uence of):							
8760,	Attending Physician: The law requires that the death certificate be executed in death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical E		.,	<b>,</b>								
687	ificate g phys is the	edic		d									
Вох	leath certific attending p for use as t	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		☐ Ectopic pregnanc	v			23d. Date of de		
B.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of o		Other (specify)			. ]	Month	Day Y	'ear
P.O.	that the de ned by the a detached	Physician/Me	9 Unknown						020 Di	d tobooo	use contribute to	the sauce of d	ooth?
	res th	à	Part II. Other significant condit				ngeriying cause giv	en in Part i		Yes 2		robably 4 □ U	
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Division of Vital Records,	ulng Physlcian: The n. After this certificate h funeral director, page	o Be	examiner?	ursing Home 5 R		6 Other (Sne	ecify) (1 = =						
o	ding Phys I. After this funeral dii	Certification: To	27. Manner of Death	28a. Date of		28b. Time o		y at	28d. Describ			LT ES	p. e. Kindle
į	uttendIn death. ctor: Af y the fur	atio	Z LI Accident	tigation		,,	M 1 🗆	Yes 2□					
iΣ	or Atter de lirecte	Įij.	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 28e. Place of building	f Injury - At ho , etc. <i>(Specii</i>	ome, farm, sti (y)	eet, factory, office		28f. Location City or	(Street al own, State	nd Number or Ri e)	ural Route Numi	ber,
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one)	al Examiner: On the bas and manne	sis of examina	ition and/or ir	ivestigation, in my	opinion, dea	ath occurred at the tin	ie, date an	id place, and due	e to the cause(s)	)
	o the	Me	29b. Signature and title of certifi				29c. Licens	e number		29d. Da	ate signed (Mont	th, Day, Year)	
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	,0		30. Name and address of perso	on who completed cause	of death (Iter	n 23a) (Type,			× 0 →	, , ,			
	10			Chacus .		10	010 60	レント	Reap		2	-1133	
	Sta	_	31. Date filed (Month, Day, Yea		gistrar's Signa	ture	arkel						
	Regist	ar	LED &	LUUJ /LAK	Sales Sand	pes - Kings	PO 24						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	Sta	ate of Ma	ryland		artment of F rtificate of I	lealth and N Death	/lental Hy	/giene Reg. Na	711119	046	02	
			Registrar  1. Decedent's Name (First, Mid	idle, Last)						2. Date of De	eath		3. Time of D	Death	
	Physicia /Medic		Judith Maril	yn Whit	more					Month Febru	ary	11 <b>,</b> 200		$A^{M}$	
	Examin		4a. Facility Name (If not institut	_	and number)				r Location of Death			. County of Dea			
			Suburban Hosp 5. Social Security Number	oital 6. Sex	7 Age	(In yrs. las	st hirthday)	Bethesd If Under 1 Year	a If Under 24 Hrs.	8. Date of Bi		Montgom 9. Bi	rthplace (State or	Foreian	
	Funeral Director		380-40-5954 Usual Residence of Decedent	1 M 2		67	Yrs.	Months Days	Hours Min.	Dec. 3	, Year, 19	941 Mi	ountry) .chigan		
	aryland show	7	10a. State 10b. Cour	ity			Town or Lo						10d. Inside City		
	the Market Marke	Director	Maryland Mont	tgomery		Germ	antov	7n 10f. Zip Code			10a. Ci	itizen of What C			
	with 3a or		19103 Gunneri	Fiold I.	270			20874					ed States		
	death	Funeral	11. Marital Status	12. Wa	as Decedent E med Forces?	ver in U.S.	13.	Was Decedent of H		14. Race - Am Black, Whi	erican Indian,				
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marked Expiriting I was by notified a once.	þ	1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorce	arried 1 [	☐Yes 2∏∏N Yes, Give ear or Dates:	ю		1 □Yes 2 ☑ No	Specify:				White		
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ñ	permi Depar Impor any Ir	d d	Butter	413li	t MO	1548	30	obert A. Pun 00 West Mont	mpnrey runer gomery Aven	nue, Rock	KOCK Ville	, Marylan	d 20850		
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	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Respiratory Failure  Due to (or as a consequence of):												
	/Medical Examiner		resulting in death)		Due to (or as : Recurre			maar					2 Years		
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4 2 0. Box	the death certific by the attending pached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown								23d. Date of d Month		ear		
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7	Physician: this certific ral director,		1 ☐ Yes 2 ☒ No	Hospita	1 Ca Inpatie				ner: 4 Nursing Ho				ecify)		
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shitmore Division	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Medical Ce		cal Examiner: (		f examinati			ime, date and place opinion, death occu						
3	To the within 7 To the comple	Me	29b. Signature and title of cert	ifier				29c. Licens	se number		29d. D	ate signed (Mor	ith, Day, Year)		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 04603 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Physician Month Feb. 12, 3:30 AM Betty Marie Walls /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore 11 Coliston Rd. Reisterstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 16,1938 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2KDX Maryland 70 Director 215-34-0962 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. The Marylar Health and Mental Hygiene. The 23 or 28a-f show other traumatic event, the Marileal Exprimer mast be notified at Director 1 □Yes 2\times\ti MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 U.S.A. Funeral 11 Coliston Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify. ģ Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 11 Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Marie Fisher Roy Derrett Harmon ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coliston Rd. Reisterstown, MD 21136 Lisa Marie Walls / Daughter Pages 1 / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Inval Service License Metro Crematory Inc. 2/12/09 Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Marrous **Physician** /Medical Due to (or as a consequence of)! Examiner Iron Deliency Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ralmonary Embalism the attending physician and ned for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ...
completely filled in by the f 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Prachtine 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/12/09 R056503 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donohue E. Palonia Re Timonium MD 21093 31. Date filed (Month, Day, Year) State FEB 17 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #13&14 State of Maryland / Department of Health and Mental Hygiene 1 - State Registral G889 3/12/engifigate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 3:10 PM ,2009 Antionia R. Armstrong /Medical 4c. County of Death a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lanham Prince George's Prince George's Doctors Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 7, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🖺 F 1942 Texas 66 Director 465-64-3516 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director Maryland | Prince George's Brentwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20722 U.S.A. 3707 Allison Street items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 Never Married 2 Married Mexican Baltimore, Maryland 21215-0036 ō 1 XXes ZXINo 10,014 Specify: þ If Yes, Give Year or Dates: Specify. White 3 X Widowed 4 ☐ Divorced Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural",
any injury or other traumatic event, I'm Medical Exe
once. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALMS TRUKE Petra Martinez Julian Vasquez Ramirez P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3707 Allison St., Brentwood, MD 20722 Michael Armstrong (Son) 20b. Place of Disposition (Name of Mountain State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Doyation 5 Dother (Specify) 2/14/09 Gilman, WV Memorial Gardens 22. Name and Address of Facility Runner Funeral Home 121 Davis St., Elkins, 21. Signa re of Fineral Service License WV 26241 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HYPORIC Physician RNTORY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Kehunu physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) Hospital: 1∐Yes 2XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation illed in by the ft 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title o certifier MSD 60925 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FA 81/86000LUCK RUAU LANAM, MD 20106 112Abe -A31 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

FER 1

8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2 10 6:07 Edward Ashby, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore

Baltimore

If Under 24 Hrs. N/A 1023 E. Biddle Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days ¥ M/ 2∏ F Months 85 10-19-1923 217-18-5542 VA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State show r than "natural", or Items 23a or 28a-f show 1 X Yes 2 □ No MD N/A **Funeral Director** Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21202 1023 E. S Biddle Street U 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry unk Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked o William Ashby Lizzie Franklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1023 E. Biddle Street Mary Ashby-Wife Balto, MD 21202 permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-14-2009 Randallstown, MD King Memorial 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee North Avenue Balto, MD 21202 1101 E. Approximate Interval Between Onset and Death 23a. Part 1, Enter the diseas, of complications that aused the death. Do not enter the mode of dying, such as carding or respiratory arrest shock, or heart failure. Ust only one cause in 9 ch line. shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Leno **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Il-transit that the death certificate be executed Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical as attending use 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 2 No the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed yes 2 has page 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home Hospital: 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

P.O. Division of Vital Records, or Attending after death. Director: Af Hospital

filled in by within 24 hours a

To the Funeral D

completely filled i

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

SHIANG 31. Date filed (Month, Day, Year) State

29a, Certifier

Medical

MI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BEATRICE ALLUISI 12:10 PM FEBRUARY 16 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GILCHRIST CENTER TOWSON BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🙀 F Yrs. 218-26-2733 Usual Residence of Decedent Director 79 12/10/1929 MARYLAND 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE PARKVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1739 WHITE OAK AVENUE 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: \$ 3 ₩ Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. College (1-4or 5+) SECRETARY CATHOLIC CENTER 12 should be filed with and Mental Hygier 7 is marked other the 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN FLAHERTY WILLIAM DRESSEL ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar Department of Health a Important; If item 27 is any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date

20c. Location - City or Town, State JEAN ALLUISI/DAUGHTER 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 2/19/2009 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death rart 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LARYNGEAL CANCER HONTHS **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of : attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760, cate has been signed by page 2 should be detack To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific: completely filled in by the funeral director. Be Certification: To

altimoré, Maryland 21215-0036

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certific

D64395

FEBRUARY 17, 2009

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHARLES ST, SUITE 209 BALTIMORE, MO 21204 DOBERMAN, MO

State Registrar

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Februar DALLON Barne 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Bayview Medical Center N/A 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year! Months Davs Hours 147-54-0325 49 Director FEB 8, 1960 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d Inside City Limits 28a-f show 1 ☐ Yes 2 X No MD Baltimore Dunda1k 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? s 23a or 2 2031 Paulette Road, Apt 2 21222 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. r than "natural", or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene innortant: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Experience once. Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Barksdale Mary Barnes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2031 Paulette Road, Apt 2 Dundalk, MD 21222 Louise Barnes/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc.2/17/09 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility

Cremation Society of Maryland, Inc 299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to fir as a consequence of): **Physician** minuse /Medical Examiner Palmonary aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-t Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy certificate fibrill 29 1 ☐ Yes 2. No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 □ No 1X Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ al or Attending P s after death. I Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Hospital o 24 hours aff e Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

To the within 2

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Vital

of

Division

Attending Physician;

State Registrar

29d. Date signed (Month, Day, Year)

D0028684

Hopkini Bryrain sedical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

FEB18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** p February 11, 2009 10:15 ™M Richard Bohan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Potomac Potomac Montgomery 8. Date of Birth (Month, Day, ) June 17, 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1927 Funeral Days Hours 1½ M 2□ F Min Months 81 062-20-6611 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show a marke event, it is forced by the force it is the control of the control o 1 XYes 2 No Director Maryland Montgomery North Bethesda 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20852 U.S.A. # 416 5550 Tuckerman Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give WWII Specify: 2 White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director of Intergrated 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Philadelphia Elementary/Secondary (0-12) College (1-4or 5+) Naval Shipyard Logistics Support 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Margaret O'Neill Jeremiah Bohan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important; If item 27 is
any injury or other trau Paula Bohan O'Brien (Daughter) 5707 Gloster Rd., Bethesda, MD 20816 20b. Place of Disposition (Name of Brigamete General Williams)
Doyle Veterans Cemetery 2/17/09 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State N. Hanover Twp., NJ 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley Funeral Home 601 Rt. 73 South, Marlton, NJ 08053 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Conrestive Heart Failure /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a Ö 9 🗌 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 N Unknown cate has been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No perform 2 No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Fafter death. 1 X Natural 5 Pending investigation nours after death.
neral Director; Af 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbalance: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0054566 February 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 9801 Georgia Ave., Silver Spring, MD 20902 Sunitha Bhogavilli, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 31 per DVR 9888 2/18/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 12, 2009 Clayton Lewis Burger 4:00 P. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 113 Hughes Shore Road Middle River Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours Min 91 215-12-8815 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 🔀 No Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Hughes Shore Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐No Specify: Specify: 3 ₩ Widowed 4 Divorced WII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Edwin Burger Nina Walizer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Richard Burger - Son 113 Hughes Shore Road Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 02-17-2009 Baltimore, Maryland ,22. Name and Address of Facility 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Servina 23a. Part1. Enter the disease, or complice shock, or heart-failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Deat tortic Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year □Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □Yes 2 **N**0 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined

the Hospital or Attending Physician; The law requires that the death certificate be executed and burial-tran ned by the attending physician detached for use as the buria signed by has page 2 certificate After this death. 24 hours after deatle Funeral Director;

Certification: To in by the

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

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Completed

Be

Medical

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, The Madical Examinar and the manifical

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

the 2 0 State Registrar

GOLDMAN MD Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2/13/09

MD.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death give street and number) Examiner Baltimole int Date of Birth (Month, Day, 9. Birthplace (State Country) (State or Foreign 7. Age (In yrs. last birthday) Under 1 Year **Funeral** Months Days 1 □ M 2 1 2 1 Director 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code ö 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No ō 1 ☐Yes 2 No 2 Specify: Back 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT se retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Eather's Name (First, Middle, 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licens 23a. Part 1. Enter the us ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CELL MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se rentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Year Month Day 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 🗌 No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate 2 **X** No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{XOther} \( \text{(Specify)} \) Hospital: 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes within 24 hours after death.

To the Funeral Director: A 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Registrar

Medical

31. Date filed (Month, Day, Year) 18

29b. Signature and title of certifier

29a. Certifier

(Check only

DANIEUE DOBERMAN, MO 6565 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N CHARLES ST, SUITE 209

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMONE, MO 21204

3 Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

09-01169	
Nathaniel Butler	

thaniel Butler		- For State	ate of Maryla	and / Depa <i>Cer</i>	rtment of tificate of	Health Death	and I	Mental	Hygier		. No.	200	9 0	461
Physicia		egistrar I. Decedent's Name (First, Middi	e,Last)			···		(d)		e of Death	Dav Ye	ear	3. Time of Deal	th
edical Examir			EL BUTLER	2						oruary 9,	2009		0802 hrs	
		4a. Facility Name (if not institution	n, give street and nu	umber)	4	b. City, Tow		cation of De	eath		4c. County			
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Funeral	7	5. Social Security Number	6. Sex	7. Age (in yrs. la	ast birthday)	If Under 1 Months	Days		Min.			Foreign	MARYLA	AND
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or 28a	Director		ON CEDEEM				212	17			U.S	.A.		
death writ the Maryland or items 23a or 28a-f sho must be notified at once.		535 WILSO 11. Marital Status	ON STREET	cedent Ever in U.	.S. 13. Wa	s Decedent	of Hispa	nic Origin?	? (Specify	Yes or No-	14. Ra		an Indian, Blac	ck,
ath w	Funeral	1 Never Married 2 N			If Y	es, specify (	Cuban, N	Mexican, Pu	uerto Rican	, etc.)				
ter de		3 Widowed 4 X Di	vorced If Yes, Give Ye or Dates:			Yes 2 X						y: BLA		
215-0036  be filed within 72 hours after death with the Maryland half Hygiene. Red other than "natural", or items 23a or 28a-f she cut, the Medical Examiner must be notified at once	d b	15. Decedent's Education (Spe	ecify only highest gra	ade completed)	16a. Deceden	t's Usual Oo ost of working	cupation	n (Give kind O NOT use	d of work de e retired)	one	16b. Kind of	Business/Ir	naustry	1.
72 hr	Completed	Elementary/Secondary (0-12)	) College	(1-4 or 5+)							N/	7\		
vithin ene.	티	12th grade			U	NEMPL	OYEI	) Mother's h	Name (First	. Middle, M	IN / laiden Surnar		<del></del>	
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1215-0036 Ide filted within 72 hours after dental Hygiene "marked other than "matural", event, the Medical Examiner	o Be	PAPPOSE Bit 19a. Informant's Name/Relation	UTLER		19b. Mailing	g Address	(Street	and Numbe	er or Rural F		ber, City or T	own, State	, Zip Code)	
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DOF Bages l at of l other	1	1 Burial 2 X Crematic		from State ME	ETRO CRE		Y		02-14	-09	BALTI	MORE,	MARYL	AND
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Depart neutr of Health and Mental Hygieus important: If item 27 is marked other than 'injury or other traumatic event, the Medical.		4 Donation 5 Other 21. Signature of Pungral Service	specify:		22.1	Name and A	ddress	of Facility	COMM	IINTTY	FUNER	AL HO	ME P.A	
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Box 68760 e death certificate be the attending physical for use as the bu	sician/Me	23b. Was decedent pregnant in past 12 months?		e birth egnant at time of o	_	etal death other (Spec	3	Ectopic	pregnancy		None	11	Day	
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tal Rec rian: The certificate ector, page		25. Was case referred to med	ical				6.Place	of Death (	Check only	one)				
Vital Rec ysician: The his certificate director, page	Be	examiner?	Hospital: 1	Inpatient 2	✓ ER/Outpatie	nt 3 D	OA	Other <sub>4</sub>	Nursing H		Residence		er:	
1 of Vital Records, ling Physician. The law require After this certificate has been si funeral director, page 2 should l	<u>ا</u> ا	1 ✓ Yes 2 No 27. Manner of Death	28a. D.	ate of Injury	28b. Time o	f Injury 2		ry at Work?		d. Describe	how injury or	curred		
on on ath.	ļ ģ		ending Fd	2/9/09	Fd 7:2			res 2X		nk				City
Division piral or Attendi ours after death. feral Director: /	Certification:		ould not be	Place of Injury - Af		eet, factory	office b	uilding, etc	c. 28f	. Location or Town,	(Street and N State) 535	Wils	Rural Route Nu Son St	mber, City
Division of price of the price	l in	4 Homicide	etermined (Spec	• .					B	altim	ore, M	עני		
		29a. Certifier Certifying	Physician: To the Examiner: On the ba	best of my knowless of examination	edge, death occ	curred at the nation, in my	time, da opinion	ate and pla ı, death occ	ice, and due curred at the	e to the cau e time, date	e and place, a	and due to	the cause(s)	
To the Hos within 24 h	Medical	- 13	and mann	er stated.				e number					fonth, Day, Yea	ir)
	Σ	29b. Signature and title of cer					O.C.				Februa	ry 10, 20	009	
		30. Name and address of per	non who com-lated	cause of death /It	em 23a)									
6		30. Name and address of per Ana Rubio MD.	son who completed t Assistant Medic	al Examiner	111 Penn	Street, E	Baltimo	ore, MD	21201					
<u> </u>	State			. Registrar's Sign		4								
Pagi			109 /2	cas A	back									

AN LEWIS BRIDENBAUCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 15 10:00 PM 02 2009 John Lewis Breidenbaugh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Arm, Maryland Baltimore 12631 Manor Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/12/1911 **Funeral** Days 1**X** M 2□ F Months 97 Maryland Director 215-07-9273 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 27 is marked other than "natural", or liems 23a or 28a-f shov traumatic event, the Modical Eventines must be notified at 1 ☐ Yes 2 No Director MD Baltimore Glen Arm 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21057 12631 Manor Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black. White, etc. Armed Forces? 1 ☐ Yes 2 💢 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2**X** No Specify: ò 3 XWidowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Auto Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental <u>Ida Elizabeth Naszinger</u> John Conrad Breidenbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau 3 Dolly Green Court - Phoenix, Maryland 21131 Grace E. Miller (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/19/2009 Long Green, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 60 11750 Belair Road - Kingsville, Maryland 21087 assaks 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart Congestive 10 yrs Physician /Medical Due to (or as a consequence of): 10 yrs. Examiner Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53156 2-16-09 Adam Road Cockeys ville MD 21030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMUN L 31. Date filed-(Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

BGALL

Kashy Grae 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KES 000

Sinai hospital of Baltimon, 2401 U. Behadne one

29d. Date signed (Month, Day, Year)

2009

		_	State of Maryland / Department  - For Certificate  Certificate			ental Hyg	iene eg. No $20$	n 9	04614
			Registrar  1. Decedent's Name (First, Middle, Last)		- I	2. Date of Deat	h		3. Time of Death
	Physicia /Medic		Frank Lee Cochran			FEB	17, 20	)09	11:30a M
	Examin			ocation of Death		4c. County	of Death		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9 Rirthn	lace (State or Foreign
	Director		371-05-0242 X 95 Yrs. 95	Days	Hours Will.	MAR 17,	1913	New	York
	rland ow		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location					1	0d. Inside City Limits
	e Mary Ba-f sh	ctor	Maryland Carroll Sykes		е				1 ∐Yes 2 X No
	h with th	al Dire	10e. Street and Number 7200 Third Avenue G11		784	1	0g. Citizen of N USA	Vhat Coun	itry?
20	should be filed within 72 hours after death with the Maryland rund Mental Hygiene. In Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Modical Exprainer mast be notified at	by Funeral Director	Armed Forces? If Yes, speci 1 □ Never Married 2 Married If Yes 2 M No 1 □ Yes 2 M No 1 □ Yes 3 M No 1 □ Yes 3 M No	cify Cuban	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		ce - Americ ck, White, e	
0500-c	2 hours atural" cal Ex		3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usua	al Occupat	ion		16b. Kind of B		
7 13	ithin 72 ne. nan "ni	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	rk done du se retired)	ring most of workii	ng II	Archit	octur	· A
17 B	filed w Hygier ther th		17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, I			
yland	uld be Mental rked o	To Be	Frank L. Cochran		Mary	S. Bris	scoe		
Mary	nd 2 shor alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Frank Blair Cochran/son  19b. Mailing Address 433 Edgewo	(Street ar ood A	nd Number or Aura venue Nev	Naven, W Haven,	CT 06	State, Zip 511	Code)
saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 28a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	5	20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Namcemetery, crematory or of All County Crem			es,Inc	20c. Location - Sykesv	ille,	MD
Da	permit Depart Import any inj once.	w s	21. Signature of Funeral Service Licensee Haight P.O. Bo	Fune ox 19	ral Home 5 Sykesv	, P.A. ille, MI	21784	(410	795-1400)
		. I	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.			or respiratory arr	est,		Approximate Interval Between Onset and Death
M.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Convicte heazt  Due to (or as a consequence of):	ble	ock			-	
	Examiner								
-	is We	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events cause.						
,	execu In and ial-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):						
8/00,	ficate be executed physician and sthe burial-transit	dical	d						
O. BOX 0	Attending Physician: The law requires that the death certific ar death. The tribs certificate has been signed by the attending pector. After this certificate has been signed by the funeral director, page 2 should be detached for use as by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (sp.					te of delive	ery Day Year
ds, r.	ires that the signed by the detaction	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying of CHR(n) C AWACK HOMICARON	ause giver	n in Part I.		bacco use contribute to the cause of death?		
Records,	w requ	letec	Chemic Remal dueroe			24a. Was a		Were auto	psy findings available
ב ב	The la ate ha: page 2	Completed				autops perform	ned?	prior to co death? 1 🗆 Yes	mpletion of cause of 2 ☐ No
V Ital	ician; certific ector,	Be	25. Was case referred to medical examiner?  Hospital:  Hospital:   Hospital:   Hospital:	Othou	26. Place of Death				
0	g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 2	OA Otrici 28c. Injury Work?	4 ☐ Nursing Ho	me 5 Reside 28d. Describe he			(y)
SIOL	tendin eath. tor: Aff the fur	catio	2 Accident investigation M	1 □ Y	es 2 □No				(B) H (
DIVISION	al or At s after d I Direct d in by	Certification: To	3 ☐ Suicide 4 ☐ Homicide	y, office		281. Location (Si City or Town		er or Hura	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate in completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.						
, care	Vithir To th comp	Me	Los, organization and a second	c. License	number	2	9d. Date signe		
	(A.Fv		- American		000		2/17/	500c	(
	10	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  THOMAS K. GALVA IN MO 2011 STOP	PIL M	SONAS	WES.W	IN STE	~ m	anyladaus
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	ricgisti		TER 18 2000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mont Dav Veal **Physician** 200 /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death street and number) Examiner 8. Date of Birth (Month, Day, FEB 12 Social Security Number . Year) 938 **Funeral** Min. 1**25**M 2□F Days Hours Months Maryland 212-36-0325 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show the Medical Examiner must be notified at 1 □Yes 2 □XNo Director Sykesville Howard Maryland 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō with 21784 USA 1150 Underwood Road items 23a Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc within 72 hours after 1 ☐ Never Married 2 ☐ arried White 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Construction Supervisor permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important; If Item 27 is marked other any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis E. Crane Helen Jones ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1150 Underwood Road Sykesville, MD 21784 Connie Crane - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 2-20°at°09 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD All County Cremation Services, Inc. 4 Donation 5 Dother (Specify) Halght Funeral Mone & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licen (410-795-1400) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a P.0. care has been signed by the page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The certificate 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes ospital or Attending Physiclan: hours after death, uneral Director; After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined within 24 hours after des To the Funeral Directon completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 / Certifying Ph. sician: the est my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the process of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and a per stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar ne and address of person

Year

31. Date filed (Month, Day,

(Item 23a) Tyre, Print

Registrar's Signature

			State of Maryland / Dep			
	_		Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death		eg. Ng2009 04616
	Physicia	an			2. Date of Death Month	Day Year
***	/Medic		Barbara Ann Cole  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	February	14, 2009   3:15 P M   4c. County of Death
1	Examin	er	Casey House	Rockville	201	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hr		
	Director		230-72-5219 1□ M 2XF 57 Yrs.	Months Days Hours Mir	June 16,	1951 Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl f sho	Po	Maryland Prince George's Hyattsv:			1 Xves 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?
	h with	al D	4911 Avondale Road	20782		U.S.A.
	ems deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
36	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 □Yes 2 No Specify:	110 1110011, 010.)	Black, White, etc.  Specify: D11-
0	hours tural	q pa	3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Dece	edent's Usual Occupation		DIACK
5	in 72 n "na Nedic	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of we DO NOT use retired)	orking	6b. Kind of Business/Industry
212	y with giene rr thau	E O	Elementary/Secondary (0-12)   College (1-4or 5+)	ilities Coordinat		Law Firm
פ	al Hy al Hy lothe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, M	flaiden Surname)
yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations in ust be notified at	၉	Robert Lee Ford	Joanne	Moseley	
Maryland 21215-0036	es 1 and 2 should b of Health and Ment i item 27 is marked r other traumatic e			ing Address (Street and Number or F		
e,	1 and 2 Health tem 27 i			Avondale Rd., H		
ğ			TES Dunai 2 Li Cremation 3 Li nemoval nom State	osition (Name of matory or other place)		20c. Location - City or Town, State
Baltimore,	permit. Pag Department Important: I any injury o					Caroline County, VA
ä	any per			2. Name and Address of Facility JOSEPH Jenkins, J		l Home ichmond, VA 23220
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er			est. Approximate
P	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Progressive Multi-	ifocal Laukoancon	halonathu	Interval Between Onset and Death
	/Medical		resulting in death)  a. Trogressive Fitte:  Due to (or as a consequence of):	trocar Leukoence	naropatny	
	Examiner		Sequentially list conditions. b.			
(/ ]	sit isit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c.			
4	execur and al-trar	xan	that initiated events resulting in death) Last C		<del></del>	
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	Tifficating phy as the	ledi			-	
Rox B	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?   23c. If yes, outcome of pregnancy   1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
	e dea the at sed fo	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
J.	nat th	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	underlying earlies given in Port I	220 Did tobe	acco use contribute to the cause of death?
Vital Records,	igne igne be c	Š	Hypertension	inderlying cause given in Part I.		s 2 □ No 3 □ Probably 4 ☑ Unknown
o i	been should	etec	Congestive Heart Failure		-	
ě j	cate has b	Completed	Congestive heart railure		24a. Was an autopsy perform	prior to completion of cause of
īg ˈ	sician: The lay certificate has rector, page 2:		25. Was case referred to medical	26 Plane of De	1 □Yes 2	A No 1 □ Yes 2 □ No
5	ysicii is cer direct	o Be	examiner? 1 ☐ Yes 2 █ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor	eath (Check only one Home 5 Thesider	nce 6 XOther (Specify) Hospice
בס ר	ffer th	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)  Injury		28d. Describe hov	
	endir eath. or: Ai	atic	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION	or Au fter de lirect n by 1	ertification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
ב ב	ar a	ပ	29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea:	the account of the time of the country		
T T	24 hc 24 hc Fun etely	Medical	29a. Certifier (Check only one)  1	nvestigation, in my opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
4	vithin To the	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
	7 - 0		Jocelyne KouATCHOU	D00637	48 Fe	ebruary 15, 2009
	li li	1	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
	- 1		Jocelyne Kouatchou, MD 6001 Munca	ster Mill Rd., R	ockville,	MD 20855
		_	31. Date filed (Ments, Day, Year) 2000 32/ Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day 3 John Wilfred Cole EPRUARY 2860 25:55AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center owson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year May 12, 1936 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F Days 219-32-7814 72 Mary land Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Modified Examinist be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore Director 1 ☐ Yes 2XXNo 10e. Street and Number 2420 Lampost Lane 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ Morea If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White ģ 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finance Corp. U.S. Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Vincent Cole Margaret Mary Malloy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Cole / Wife 2420 Lampost Lane Baltimore Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 2-18-09 Timonium Maryland 21. Signature of Funeral Service Licenses reopard didrick Facilia 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans MYOCARDIAL INFARCTION Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) as been signed by the 2 should be detached ☐Yes 2☐No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy certificate ha 2 No 1 □ Yes 2 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Marmer of Death 1 Natural Date of Injury (Month, Day, Year) 28a. 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46356 ress of person who completed cause of death (If rfi 23a) (Type, Print) 6+ 30. Name and a

State Registrar

DHMH 17 Rev 1/2001

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TOWSON, MARYLAND

M.D.

32. Regisfrar's Signature

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KHOSROW 31. Date filed (Month, Day, Year) 7601

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 9, 2009 **Physician** 6:55 P M Dorothy Catherine Clark February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Edgemere 7219 Waldman Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 216-28-8644 1 □ M 2 🗓 F Yrs. Director Jan. 29,1932 Maryland Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show other than white reward to the medical Expansion of the profiling at 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1X Yes 2 □ No Director Baltimore City Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 United States 2861 Pelham Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ÊNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Bush Joseph Ritger ۵ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgemere, Maryland 21219 7219 Waldman Ave. Sharon Keene (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If it any Injury or o 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/13/2009 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bulla Ricks Fufferal Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the spease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart in the list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AWANCE NON-SMAIL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) I Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours: after death.

24 hours: after death.

Funeral Director After this certificate has been signed by the attending physician and attending by the unertal director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 🔲 Ectopic pregnancy 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes Daughter's 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

3243 Elliott Street

Baltimore, Maryland

21224

30. Name and address of person who completed cause of death (Item 23 (Type, Print)

MD

32. Registrar's Signature

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 () () 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 15 A M DONALD CRISLIP 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 1018 Marleigh Circle Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. September 29,1957 5. Social Security Number 6. Sex 1 → M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 217-70-0488 51 Yrs. Director Maryland Usual Residence of Decedent 10b. County 10a. State show 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examinar cast be notified at Director 1 ☐ Yes 2 🛣 No Maryland Baltimore 28a-f Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1018 Marleigh Circle 21204 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ▼No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 21215-0036 o, If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important; if item 27 is marked other than any injury or other traumatic event, the Magnes, injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Supervisor Steel filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Gilbert B. Crislip Ruby M. Hendershot ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Crislip wife 1018 Marleigh Circle, Towson, Maryland 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. 20, 2009 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 10 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neuroepolocia Concinen disease or condition resulting in death) cel /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last baeco Examiner Due to (or as a consequence of): that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for in the past 12 months? Month Day 5 ☐ Other (specify) P.O. the 1 □ Yes 2  $\square$  No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? Records. <u>Ş</u> pe page 2 should 1⊈Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Physician: The Vital 2 □ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 20 No Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28h Time of After 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of eertifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type,

Registrar
DHMH 17 Rev 1/2001

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State

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#!\*PERFH, G888, 2/26709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year FEBRUARY 12,2009 MARY JANE CAPRINOLO 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOLLY HILL NURING AND REHAB. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 □ xF 89 Yrs. 220-07-3872 MARYLAND 12-3-1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits BALTIMORE PARKTON 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20030 CAMERON MILL ROAD 21120 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏋 ☐ No Specify. WHITE Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) CALABRATOR BENDIX FREEZE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM KELLEY E. MARCARET A.Anna (GUNTHER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DEBORA HUBER/GRANDDAUGHTER 20030 CAMERON HILL RD PARKTON, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GARDENS OF FAITH 2-16-2009 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced Athorosdenote (and-oversalan disease or condition 1040+ resulting in death) Due to (or as a consequence of): dements Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dub to (or as a consequence of) Due to (or as a consequence of): JF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural

/Medical Examiner 'uted and and burial-transit death certificate be exec Division or Vital Records, P.O. Box 68760, attending physician as nse for signed by the at d be detached fo To the Hospital or Attending Physician: The Taw Torkers within 24 hours after death.

To the Funeral Director: After this certificate has been si

Examiner Physician/Medical Completed Be ို Certification: Medical

**Physician** 

/Medical

10a. State

MD

Examiner

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

the Medical

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot

**Physician** 

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show

Saltimore, Maryland 21215-0036

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

miler- p Kithing mo

6 ☐ Could not be

determined

031865

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gustan Street m 206

Baetimore

31. Date filed (Month, Day, Year) 8 2009

2 ☐ Accident

3 Suicide

29a. Certifier

4 ☐ Hornicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Ε. Elizabeth Cooper February 15 2009 5:35 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brooklyn Park Anne Arundel <u>Genesis Nursing Home</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/18/1925 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 👽 F 160-20-6702 83 Director Pennsylvania Usual Residence of Decedent the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Maryland Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 2 rry or other traumatic event, the Modical Examinar mast be in 113A 2nd Avenue 21225 United States Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White Specify: 3 A Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Secretary Elementary/Secondary (0-12) College (1-4or 5+) Steel Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Cowan Elizabeth Phillips ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113-A 2nd Avenue, Brooklyn Park, MD 21225 Thomas W. Price, Sr.- nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Port Richey permit. Pages 1 Department of H Important: If ite any injury or ot Meadowlawn Memorial 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-18-09 Gardens
22. Name and Address of FacilityGary L. Kaufman Funeral Home, Inc Florida 21. Signature of Funeral Service Licensee M00053 7250 Washington Blvd, Elkridge, Maryland, 21075 ar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) wy dis /Medical Du to as a consequence of): Examiner 18/107G Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a conseque Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physiciar Physician/Medical the attending p use as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔑 Unknown peen: 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Wall Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number w r ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and RoAd Glen Burnie MD 21061 MUNERA J842 .32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04622 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Campbell 9:35 AM Carmelite G. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner baitimore ranklin LIGIC 8. Date of Birth Month, Day, Year, June 28 1924 9. Birthplace (State or Foreign Country) Baltimore, Maryland (In yrs. last birthday) 5. Social Security Number Funeral 1□ M 2□ F Months Days Hours Min 218 14 6295 84 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any highry or other traumatic event, It Medical Evarinational to rottle of any once. 1 ☐ Yes 2 ☐ No Director Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 2 G Raylon Drive Completed by Funeral Campbell, Carmelite Itimore, Maryland 21215-0036 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates Specify: 3 Midowed 4 Divorced White Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk McCormick Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Barry Theresa Spence ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21220 Patricia A. Baracco (Daughter) 1516 Chesapeake Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery February 18, 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland sign ure of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Ineumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner that the death certificate be executed burial-transit and Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 □ Yes 2 🔽 1 ☐ Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P after death. I Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier P0062573

State Registrar 30. Name and address of pe

31. Date filed (Month, Day,

ebra

Year

18200

Square Drive Bailimore, Md

who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb 17, Catherine S. Covington 2009 **Physician** 9:00 A /Medical 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Sunrise Assisted Living Pikesville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1070371917 1 □ M 2√□ F 213.18.7891 91 Maryland Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2x No Director Maryland Baltimore Pikesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 3800 Old Court Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No White Specify Specify. þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olive Edna Collins William Frank Sauers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau 178th Avenue N.E; Redmond, Washington 98052 Kenneth S. Covington Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/21/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of uneral Service Livers MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic 1091 Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of) Examiner certificate be executed and resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical attending 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Yo Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy page 2 No 1□ Yes Physician: funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Be Assisted Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 ☐ Yes 2 ☐ 100 1 Inpatient 2 ER/Outpatient 3 DOA 9 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner eath 28d. Describe how injury occurred Certification: or Attending 1 tural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

ZOME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.

GINS BERG

32. Registrar's

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

120020964 RESTERS 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Robert Stephen Clements 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner VAMC Baltimore altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) -371g **Funeral** Days 1 M 2 □ F Months Hours 52 Director 29, 1956 Washington DC Ju1y Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State a or 28a-f show be notified at 10b. County 10d. Inside City Limits MD Baltimore Co. Reisterstown 1:□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with then of Health and Mental Hygiene. items 23a c 218 Stocksdale Ave 21136 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: Specify: white 3 ☐ Wirlawed 4 ₹ Divarced Year or Dates: Completed er than "natur , the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder construction 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen A. Clements Marlise Danneffel မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen A. Clements- father Item 27 other tra 218 Stocksdale Ave., Reisterstown, MD 21136 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 2/16/09 Hampstead, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136 Ting Part1. Enter the disease, or conshock, or heart failure. List only implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Imn ediate Cause (Final **Physician** discase or condition resulting in death) /Medical Due to (or as a conse uence of): Examiner IVer Md Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) by the a ☐Yes 2☐No 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No nas e 2 autopsy performe certificate 2 0 No or Attending Physician: ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA မ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 [Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number A V 417 G 435 K 19082 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Greene St. Baltimore, MD 21201 line Jacque Sar

Registrar

State

31. Date filed (Month, Day, Year)

FEB18

Market

32. Pagistrar's Signature

2344

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 12 2009 **Physician ERMA** CUNIX 2:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) HUNGARY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 01/18/1912 1 □ M 2 💢 F 298-07-4880 97 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfeal Examination and injury or other traumatic event, the Wedfeal Examination and once. 10a. State 1 □Yes 2 No Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 Funeral 725 MT. WILSON LANE, #518 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕱 No Specify: Specify: WHITE Be Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES BRIDAL STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JOSEPH** FRANKOWITZ ROSE UNKNOWN ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 BRETON WAY, BALTIMORE, CECELIA EISENBERG / DAUGHTER MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State BETH ABRAHAM CEMETERY 02/13/2009 DAYTON, OH 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21/ Signature of Funeral Sovice License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ZHEIMER'S Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, flary leading to find clath cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760, physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year signed by the a 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

Ineral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely one) XICRNP 29b. Signature and title of certifier R125808 V, comp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIN ST. STE 200 Reisters Villanueva, CRNP 25 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17, 19a per fh g888 2-25-09 vt State of Maryland 7 Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 2009 **Physician** DeLores 1116 Christine DeShields Februa /Medical 4a. Facility Name (If not institution, give street and number, 4b. City Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2 🔀 F 220-76-7745 Director 2-8-1959 49 MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Items 23a or 28a-f show 1 XYes 2 □ No Directo Baltimore 10f. Zip Code MD 10g. Citizen of What Country? 10e. Street and Number 2832 Lake Avenue USA 21213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc traumatic event, the the digal Examination filed within 72 hours after Never Married 2☐ Married 5-0036 ō 1 ☐Yes 2 No Specify Black Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 3 <u>years</u> Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be l 2 should be fil h and Mental H William Henry DeShields marked William Julia Ann Thames 2 Baltimore, Mary 19a Informant's Name/Relationship (Type Print)
William Henry DeShields
William Henry-Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 2832 Lake Avenue Balto, MD 21213 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 2-13-2009 Lansdown, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H y la Balto, 1101 E. North Avenue MD21202 ware Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final umonai disla hronic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a d be detached f 1 ☐Yes o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D0062735

Registrar
DHMH 17 Rev 1/2001

State

5601

Loch Raven Blvd, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mi

32. Registrar's Signature

Johnal

odrna

31. Date filed (Month, Day, Year)

Denkenberger

Months

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min.

Timonium

Days

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Reg. No

2. Date of Death

Month Day 14, Year Pebruary 14, 2009

Date of Birth (Month, Day, Year)

4c. County of Death

Baltimore Co.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Year

West Virginia

6:20 AM

Dhysisian	
Physician /Medical	
Examiner	

1 - For State Registrar

10a. State

5. Social Security Number

215-40-7114 Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

6 Sex

Stella Maris Hospice

10b. County

Patricia

66

Ann

7. Age (In yrs. last birthday)

10c. City, Town or Location

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examitrar must be multiled at Directo Funeral 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite ≥ Completed Be

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Examine

Physician/Medical

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Completed

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Medical Certification: To

6:20 а.ш.

2009

FEBRUARY

Baltimore, Maryland 21215-0036

permit. Page Department o Important: If any injury or Physician /Medical Examiner

Health a ortant: If item 27 injury or other t

Pages 1

attending physician for use as the burial Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

PATRICIA DENKENBERGER

1 ☐ Yes 2 X No Dunda1k Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 8206 Bear Creek Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. □Yes 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify If Yes, Give Specify: 3 ⊠ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vivian L. Whetsell George Musick, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela Piorunski (Daughter) 8206 Bear Creek Drive Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2/18/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. ide 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \times$  Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one Nurse Practitionnermer stated.)

Nurse Practitionnermer stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie e theef CCD C157629 2/16/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAUF, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 914 PM re grand 500 /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 65 21, 1944 Pennsylvania 185-34-2833 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 Yes 2 No Examiner must be notified Directo Northumberland Milton 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 2 Funeral 1075 Mahoning Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married ō Specify: White 1 ☐ Yes 2 XNo Specify 2 3 Widowed 4 Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Ships Parts Store Clerk Dept. of Navy 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph T. DiRocco Angelina DiNatale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. Marie Ford (Sister) 2107 Pine Valley Drive Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)

St Joseph Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from Feb. 14, 2009 Milton, Pa. Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac **Physician** VV25+ /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pertension attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2. No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🗌 No 1 Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DDA Medical Certification: To within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural **Injury** 1 Yes 2 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Brandon 600 North Wolfe St, Baltimore, MD, 21287 09:0 64 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar

DHMH 17 Rev 1/2001

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16, 2009 **Physician** 6:40 AM M February William Francis Desmond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Fairland Adventist Nursing Silver Spring Home If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 10/13/1953 9. Birthplace (State or Foreign Country)

MI 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Davs Hours Min. 1 🗷 M 2 🗆 F 55 Director 057-40-7005 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c City Town or Location 10d. Inside City Limits 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Takoma Park Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20912-Completed by Funeral 238 Park Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 Tyes 2 ™ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Various Companies 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joan M. Doherty William F. Desmond Jr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 238 Park Ave. Takoma Park, MD 20912-If item 27 i or other tra Dennis M. Desmond/Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 Feb 18 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Beltsville, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licens moc382 led Lohman 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ADVANCED 6 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Box 68760, physician use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. ned by the a 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, signe be ( Completed by CHRUNIC OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EMENTIA page 2 s autopsy performe SFIZURE DISORDER this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 SHADY GROVERS PASSI MD KAVI

Registrar DHMH 17 Rev 1/2001

State

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh 8888 2-18-09 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** sanita Jogan 122.009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 7.4.1926 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 □ → 82 Yrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be neithed at Director 1d□¥es 2□No Baltimore M 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Burnwood Road 21239 Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or itea 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify δ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) h and Mental Hygiene. Elementary/Secondary (0-12) Nurse Health Care Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Dogan ပ္ Beulan M. Linsau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Burnwood Pod Baltimore, MI) a

| 20c. Location - City or Town, State Arnita Addisor MI) 21239 2004 permit. Pages 1 and Department of Healf Important: If item 2 any Injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2.20.2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) sood lawn 22. Name and Address of Facility Varynn C. Greene Furerul Service 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the rapage 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not re 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 4 1 🗆 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Vital 1 ☐ Yes 2 🗓 After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 2 No 1 □ Y9⁄s Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of . Varyer of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signat 29d. Date signed (Month, Day, Year) 29c. License number cause of death (Item 23a) (Type, Print) 1000 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#1,#4a, perPHYS, G888, 2/24/09, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Raymond Herman Ford **Physician** 11:50A<sup>M</sup> 30, January 2009 <u>Raymond</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Shady Crove Hosp Silver SPring S11Ver Bring

If Under 1Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Montgomery Social Security Number Birthplace (State or Foreign Country) 7, Age (In yrs. last birthday) **Funeral** Days Months 1 XM 2 □ F 577-24-7989 8, Oct. 1922 Wash. Director 86 DC Usual Residence of Decedent 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 10a. State 10b. County 1XYes 2 □ No Director DC Washington, DC the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1315 CLifton Street #208 20009 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces Pages 1 and 2 should be filed within 72 hours after 1 Tes 2 Tildes

1 Yes 2 Tildes

If Yes, Give

Year or Dates: 2 No 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ William Ford <u>Lillian</u> Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
404 E. Clifford Avenue
ALexanderia, VA 22305 19a. Informant's Name/Relationship (Type. Print) t of Health a Department of Health Important: If item 27 any injury or other troops. Lorraine Oliver/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GLenwood Cemetery 2/7/09 Washington, DC 22. Name and Address of Facility Austin Royster Funeral Home Service License 3821 14th Street, N.W., Washington, DC 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Renal Failure weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** End-Stage Dementia Years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 → No 24a. Was an autopsy performe 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 0065485 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Barbara Supanich, MD 1500 FOrest Glen Road, Silver Spring, MD

32. Registrar's Signature

20910

		-	For State Registrar	State of Maryla		Certificate of		мена пу	Reg. No.	9 04632
	Physicia		1. Decedent's Name (First, Middle, La Wes (e.g.	Fager				2. Date of De Month	Day Y	ear 0 22 Am
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	Location of Death	1	4c. County of	90
			JOHNS HOPKINS BAYN	NEW MEDICIAL C	ENTE					
Į	Funeral Director		223-00-0920	7. Age (In yr.	s. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	ay, Year)	Birthplace (State or Foreign Country)     VA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town o	r Location				10d. Inside City Limits
	Maryla f sho	P	VA Middle		ardyv					My⊡Yes 2 □ No
	r 28a-	Director	10e. Street and Number			10f. Zip Code	-		10g. Citizen of Wh	at Country?
	h with	a D	373 Glenn Cove Dr	rive		23070			United S	States
	ems 3	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Decedent of H	ispanic Origin? (S an, Mexican, Puert	specify Yes or No to Rican, etc.)		American Indian, White, etc.
736	hours after death with the Maryland tural", or Items 23a or 28a-f show Evaning two rollfind at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give Viet Year or Dates: Ex	nam	1 □Yes 2X No	Specify:		Specify:	White
5-0036	hin 72 hours aft e. an "natural", or Medic Expii	Completed	15. Decedent's En (Specify only highest gra	ducation	16a. D	ecedent's Usual Occup	during most of wor	rking	16b. Kind of Busi	ness/Industry
7	filed within 72 Hygiene. Ither than "nat	duic	Elementary/Secondary (0-12)	College (1-4or 5+)	_ "	ife. DO NOT use retired	" Scienti	st	Com	nouter
D D			17. Father's Name (First, Middle, Last			compaces			e, Maiden Surname)	1
yland	ald be Aental rked c	To Be	William B. Fager				Dorot	hy Moon	ey	
Mary	should and Mer is marke aumatic		19a. Informant's Name/Relationship (			Mailing Address (Street				
	t Health tem 27 them 27 other tr		Catherine Fager,			Glenn Cove				
Baitimore,	of = 1		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐	nemovarirom state   P	Place of D cemetery, <b>ivers</b>	isposition (Name of crematory or other place ide Memoria	al 2/17	Date 7/09		ity or Town, State  Virginia
	permit. Pag Departmen Important: any injury once.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fundamental Service Control of Service	y)		22. Name and Addre				, Great Bridge
ň	Imp any any		unot Atm		0	653 Cedar	Road, Ch	esapeak	e, VA 233	22
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do no	t enter the mode of dyir	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
- W.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Parane	opla	stic skir	n dison	der		Onset and Death
أبالوس	/Medical Examiner		resulting in dealth)	Due to (or as a conse	equence of)	:	har co	~101		
		ř	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	insequence of):  19 10 708 piratory G78481  Inservence of):					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.			1.6			
Ö,	tificate be executed g physician and as the burial-transit									
09/89	icate I physi s the b	edical	•	d						
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. Date	of delivery
o B	e death ce the attendii ned for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		Mont	h Day Year
7.	that thed the		Part II. Other significant conditions	contributing to death but not re	esulting in t	ne underlying cause giv	en in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
<b>Records</b> ,	w requires that the dispersion signed by the should be detached	d by						1 🗆	Yes 2. No 3	☐ Probably 4☐ Unknown
ဝပ္ပ	e law rei has bee je 2 shoi	Completed						24a. Was		ere autopsy findings available or to completion of cause of
_	The ate h	Som						perf	ormed?/ de	ath?  Yes 2 No
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	I I a a mitali		Tou	26. Place of Dea			
o	Phys this ral dir	2	1 ☐ Yes 2 ☑ No  27. Manper of Death	Hospital: 1 Inpatient 2	<del></del>		4 LI Nuising F		how injury occurred	
_	Attending Phyrdeath. ector; After thi	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year)	Inju	ıry Wor	y?" Yes 2□No	Zou. Describe	now injury occurred	
DIVISION	• Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farm	, street, factory, office		28f. Location	(Street and Number	or Rural Route Number,
5	Iltal or Insaft ral Dir lled in									
	ie Hospital or Attendin 124 hours after death. ie Funeral Director: Af pletely filled in by the fur	Medical	29a. Certifier (Check only one)  1 Certifying P 2 Medical Example	nysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, on and/	death occurred at the ti or investigation, in my	me, date and place prinion, death occi	e, and due to the urred at the time	e cause(s) and man , date and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (	Month, Day, Year)
			V C/////	fesia.	ent	791	00		2/13/1	99
)			30. Name and address of person who							
)	-0		1 brawn Suta 31. Date filed (Month, Day, Year)	9940 32. Registrar's Sig		STERN AV	ENUE	VALTIN	noze, m	D 21224
	Sta Registr		CER 1821		19. "	to arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 5:00P M Physician February 12 Μ. Melva Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Summit Park Health & Rehabilitation Catonsville Baltimore 9. Birthplace (State or Foreign Country)
Maryland Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y AUGUST 14, 5. Social Security Number Year) 920 **Funeral** Days 1 □ M 2 🕱 F 214-40-5805 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State orant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Modeal Examinar must be notified at 1 ☐ Yes 2 XNo Catonsville Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 1502 Frederick Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **Enoch Pratt Library** Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard L. Wright Bessie Coburn 19b. Mailing Address (Street and Number or Flural Houte Number, City or Town, State, Zip Code) 10 N. Calvert Street Suite 542 Baltimore Maryland 21202 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any injury or other traum J. Michael Holloway/ Attorney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 2/18/09 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) ,22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENTERO CUTAN EOUS Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 1 ☐ Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

**Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

28a-f show

within 72 hours after

2 should be fill and Mental F

Saltimore, Maryland 21215-0036

signed by the attending I be detached for use as certificate has b irector, page 2 sh 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, within 24 ho

To the Fune

completely f

State

29a. Certifier

4 Homicide

29b. Signature and title of certifier MD 29c. License number

D006586

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

12009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE. FERRY RD 7717 HAMMONDS

AWAN 31. Date filed (Month, Day,

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 18:38 PM **Physician** obert W. Gische 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Baynew Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 XM 2 F 10/29/1937 **Director** 216-32-5889 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "Aedical Examiner must be notified at 1 XYes 2 ☐ No Director Baltimore MD N/A 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21206 USA 4300 Parkmont Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify Specify: ≥ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellwood Owen Gischel Lillian Lycett ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is r
any Injury or other trau Baltimore, Maryland 21206 Doris Jean Gischel (wife) 4300 Parkmont Ave. Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 02/17/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, MD. 21222 Dundalk, Inc. 23a. Pert 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final spirator **Physician** 10 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of) Examiner the death certificate be executed burial-trans Lo<sup>B</sup> Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi-29c. License number 29d. Date signed (Month, Day, Year)

Registrar

2

State

Erica

31. Date filed (Month, Qay, Year)

4940 Eastern

Avenue Baltimore, MD

MID

32. Regietrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hards

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician GARDNER 0714 M ALECIA 2009 DORIS FEB 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia Birthplace (State or Foreign Country)
 New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 57 171-44-0468 Vrs 9-16-1951 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination of the reducation. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2X No Columbia Director Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21045 7171 Peace Chimes Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Mansfield Charles Levland ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Donald Gardner (Husband) 7171 Peace Chimes Court Columbia, MD 20145 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2-18-2009 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service License, while Approximate Interval Between Onset and Death 23a. Firt1. Enter the Lea. From Dice lons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ATHEROSCLEROTIC CORONARY /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any local Sciential Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 1 ∐Yes 2 🗷 No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 □ No 1 ☐Yes 2 XNo Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. within 2 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Walter Atha, M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

5755 Cedar Lane Columbia, Maryland 21044

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 50 P M Angela Glordano Feb 2000 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Year) March 4,1908 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 184-10-0092 Pennsylvania 100 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Maryland at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ellicott City 1 ☐ Yes 2 No Howard Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 USA 3317 Hibiscus Court by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 21 No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Grimaldi Nancy Barbari ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3117 Edgewood Road; Ellicott City, MD 21043 Vilma Baykaler Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/19/2009 Edgewood Mem. Park |Glen Mills, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. MD 21228 1630 Edmondson Avenue: Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septic Shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Exam Incarcerated Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renor 2 No 3 Probably 4 Unknown 1 ☐ Yes artern dicense 24b. Were autopsy findings available prior to completion of cause of death? Coronary 24a. Was an s certificate has t lirector, page 2 s autopsy perform DIabeter me 1 □Yes 2 10 No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this etely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of confiden 29c. License number Feb 15 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane BOYCE MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:35 AM mea 2009 /Medical 4a. Facility Name (If not institution, give street and no 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital bg/timore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🕶 F Hours Min 213-20-8198 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or items 23a or 28a-f shownir er must be notified at 1 Yes 2 No Be Completed by Funeral Director ltimore 10g. Citizen of What Country? 10e. Street and Number death with 21206 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 No th and Mental Hygiene. 7 Is marked other than "natural", or traumatic event, the Medical Exa... 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) nnie permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funcial Service ensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ischemia Mesenteric **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine NB the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buna Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐Yes 2 ☑No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Good samaritan Hospital 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natallia Maroz 5601 Loch Raven Blvd, BALTIMORE, MD '82 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

INEA

State of Maryland / Department of Health and Mental Hygiene Jose Fernando Gamez 1- For State Certificate of Death Q Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 10, 2009 2005 hrs Gamez **Medical Examiner** Fernando 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince Georges Hospital Center Cheverly 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** ForeigrE1Salvador Months Davs Hours Min Director 1 X M 579-13-8425 05-30-1967 41 Usual Residence of Deceden 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after eeath with the Maryland ment of Health and Mental Hygiene vient of Health and Mental Hygiene vient: If item 77 is marked other than "natural", or items 23a or 28a-f show or other tranmatic event, the Medical Examiner must be notified at once. DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ā E1Salvador 20018 1335 Downing St. N.E. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married Yes 1 X Yes 2 No specify: Salvadoran If Yes. Give Yea Specify: White Divorced 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 Laborer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Macario Zavala Rosalia Gamez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 335 Downing St. N.E. Washington DC 20018. Rhina Saravia I. (Compani<u>on</u>) 20c. Location - City or Town. State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial Department of Finjury or oth Laurel, Maryland Cement. 02-14-09 Marvland Ntl. ation 5 Oth permit. 22. Name and Address of Facility.H. Bacon Funeral Home, Inc. Signature of Funeral Se e License 14th St. N.W. Washington DC 20010. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filine. Approximate Interval **Physician** ailure. List only one cause on eag /Medical Death Multiple Injuries hediate Cause (Final disease or condition resulting in death) xamine Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy . Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown q Unknown the s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 No 3 Probably 4 V Unknown م Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has b ector, page 2 sh death? performed' Yes 2 1 V Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 26. Place of Death (Check only one 25. Was case referred to medical Be Division of Vital Hospital: 1 DOA Nursing Home 5 Residence 6 Other Inpatient 2 Inpatient 3 2 1 V Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Feb 10, 2009 (Month, Day Year) Subject pedestrian struck by vehicle 1937 hrs Natural Yes 2 ✔ No 5 Pending 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) MD 295 South ramp to New York Avenue, Cheverly, MD (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** February 11, 2009 O.C.M.E. 30. Name and address of person who complete clause of leath (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signatur 31. Date filed (Month, Day, rear) State

09-01170
Nathaniel Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

itilariici Giccii	1- For State Registrar	State of Maryland /	Certificate of D	Death	Reg.		19 0463
Physician edical Examine	1. Decedent's Nam	ne (First, Middle,Last)	GREEN		2. Date of Death Month D February 9, 2		3. Time of Death  0815 hrs
		if not institution, give street and number) Regional Hospital	4b.	City, Town, or Location of Dea Randallstown	th	4c. County of Death Baltimore Cour	nty
Funeral	5. Social Security I		(In yrs. last birthday)	If Under 1 Year   If Under 24H Months   Days   Hours   M		MM/DD/YYYY) 9. Birth Foreign	
Director	214-02 Usual Residence	5272 1 MM 2 F 2	6 Yrs.	Widthins Bays Hisdis III	ost, 11)	1982 COU	ntry) MARYLAN d
Maryland 28a-f show any d at once.	10a. State	BALTIMORE	RANDAIS	own			10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	10e. Street and Nu	A = 1/'	11 CIRCLE	211 <u>33</u>	, 10g.	Citizen of What Coun	uyr
No.	10e. Street and No. 3532 11. Marital Status 1 Never Marr	Yes 2	No If Yes	Decedent of Hispanic Origin? ( , specify Cuban, Mexican, Puer		14. Race - Americ White, etc. Specify: A	
urs after tural", aminer	3 Widowed	4 Divorced If Yes, Give Year or Dates: ducation (Specify only highest grade com	pleted) 16a. Decedent's	Usual Occupation (Give kind of	of work done	6b. Kind of Business/li	
MD 21215-0036 2 should be filed within 72 hours after death hand Mental Hygiene. 2 Tis marked other than "natural", or iten matte event, the Medical Examiner must	Elementary/Sec			t of working life. DO NOT use r	ES LIBERTY	FASTFOOD	d SALES
21215-0036 uld be filed within 77 Mental Hygiene. marked other than c event, the Medical	17. Father's Name	e (First, Middle, Last)		18 Mother's Na	ne (First, Middle, Ma	un for	
e, MD 21215-0036  I and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than 1 r traumattic event, the Medical		lame/Relationship (Type, Print )	19b. Mailing A	Address (Street and Number of + 20th St. Apr	F 6 R B	er, City or Town, State,	Zip Code)
e, land I and Healt Healt ritem	20a. Method of Di	sposition	20b. Place of Disposition	on (Name of cemetery,	Date 2	20c. Location - City or	Town, State
Page Page nent c ant: or otl		Other Specify:	Wood / Awar	CEMETERY 2	118/2069	BATTO, 1	I A.
Balti permit. Departr Import injury	W)	runeral Service Lice ee	ma	me and Address of Filipy RSh All Bl. Jo	WAYBA	Ho Md	21213
Physician √Medical	failure. List o	the disease, or complicators that caused only one cause on each line.		m de of dying, such as cardia	c or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
taminer	Immediate Cause or condition resul						7000
	Sequentially list of if any, leading to cause. Enter Und	immediate Due to (or as a conse	equence of):				
d sit	if any, leading to cause. Enter Und (Disease or injury events resulting i	that initiated C.	equence of):				
execut ian and ial - tra	X UNPENDE	d.  D AMENDED 238	a,PII,27,perN	ME, g889 3/16/	09 TT		
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ion of Vital Records, P.O. Box 687 tending Physician: The law requires that the death certifice eath. or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as the	23b. Was deceder past 12 mont  1 Yes 2  Part II. Other sig	ns?	Carried and a second	er (Specify)			
s, P.O. B ires that the d		nificant conditions contributing to deat	h but not resulting in the un	derlying cause given in Part I.		acco use contribute to	the cause of death?
v requires the speed signs of the sign of the s	Seiz	ure disorder			24a. Was ar	n   24b. Were at	utopsy findings available
Division of Vital Records, tat or Attending Physician: The law requirers after death.  al Director: After this certificate has been so be in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	——————————————————————————————————————				autops perform 1 ✓ Yes 2	ned? death?	completion of cause of es 2 No
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or Attendin after death. Director: A I in by the fur	1X Natural 2 Accident	5 Pending		1 Yes 2 No	COS Lagation (St	west and Number or Di	ural Route Number, City
Divis tal or A	1X Natural 2 Accident 3 Suicide 4 Homicide	determined (Specific)	njury - At home, farm, street	i, factory, office building, etc.	or Town, St		arar Route Number, City
Divi  To the Hospital or within 24 hours after To the Funeral Dir		Certifying Physician: To the best of m  Medical Examiner: On the basis of exa	ny knowledge, death occurre	ed at the time, date and place, on, in my opinion, death occurr	and due to the cause	e(s) and manner as sta	ted. ne cause(s)
To the H. within 24	81	and manner stated.		29c. License number		29d. Date signed (Mo	
	my	W. mos		O.C.M.E.		February 10, 20	09
× 1	30. Name and ac	dress of person who completed cause of D Assistant Medical Examine		t, Baltimore, MD 21201			
() V			ar's Signatur	Kel			

			1 - State of		artment of Health and rtificate of Death		iene 2009 04640
			Decedent's Name (First, Middle, Last)			2. Date of Death	a 3. Time of Death
	Physicia /Medic		Madeleine		Haves	Month Februar	y 6, 2009 11:30 A <sup>M</sup>
-	Examin		4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or Location of Dea	ath	4c. County of Death
أمرمه			Riderwood Village		Silver Spring	- La	Prince George's
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Min		9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	03		1002) 29	1923 France
	yland how		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	a-f s	Director	Maryland Prince George'	s   Silver S	pring		1X Yes 2 □ No
	可 or 28	Dire	10e. Street and Number		10f. Zip Code	10	Og. Citizen of What Country?
	s 23a	ra	3160 Gracefield Road		20904		U.S.A.
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Ves	dent Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	Ir's aft	by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv	е	1 □Yes 2 X No Specify:		Specify: White
Ö	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Madoal Evan men until be notified at	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	1	16b. Kind of Business/Industry
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nd	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Midfoal Evan in court to contine a	Be	17. Father's Name (First, Middle, Last)  Jean Charles Omnes			ame (First, Middle, N	
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Ma	ith an		Olivia C. Immerman – Daug	Ī	l Nibud Ct., Rocl		
ē,	f Hea		20a. Method of Disposition		osition (Name of matory or other place)		20c. Location - City or Town, State
m 0	Pages nent o nt: If i		1 M Burial 2 □ Cremation 3 □ Removal from 5 4 □ Donation 5 □ Other (Specify)		sant Cemetery 2/1	12/09	Mt. Pleasant Twp., PA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other, traumatic es once.		21. Signature of Fineral Service Licenses	2/ 2	2. Name and Address of Facility	. Europol	Home
8	88 = 88		Lennii Vell	une 18	Vincent V. Rodger 305 Pennsylvania	Ave., Irw	in, PA 15642
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not en ach line.	ter the mode of dying, such as card	iac or respiratory arre	Interval Between
	Physician		Immediate Cause (Final disease or contition a. Pneur	nonia			Onset and Death
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9	ertific ling p e as t		IF FEMALE:				
Box	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery  Month Day Year
Ö	The law requires that the death certifinate has been signed by the attending I age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☒ No 4 ☐ Pregr 9 ☐ Unknown 9 ☐ Unkn		Other (specify)		·
σ.	that the	y Ph	Part II. Other significant conditions contributing to de	ath but not resulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
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ita	iclan: The certificate ector, pag	Be C	25. Was case referred to medical examiner?		26. Place of D	eath (Check only one	
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n O	ing After une	io iii	1 22 Tatala	of Injury 28b. Time of h, <i>Day, Year)</i> Injury	Work?	28d. Describe ho	w injury occurred
isi	Il or Attending after death. Director: Afte d in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be 28e Place	of Injury - At home farm st		28f Location (Str	reet and Number or Rural Route Number,
Division of Vital Records,		Certification: To	4 Homicide determined building	of Injury - At home, farm, st ng, etc. <i>(Specify)</i>	reet, lactory, effice	City or Town	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in				th occurred at the time, date and pla		
	To the Howithin 24 To the Fu	Medical	one) and man				ate and place, and due to the cause(s)
	Vith Con	2	29b. Signature and title of certifier		29c. License number	1	9d. Date signed (Month, Day, Year)
			rulen lalan	mang M	D59524	F	ebruary 6, 2009
	10		30. Name and address of person who completed caus Loveen J. Puthumana, MD		Print) cefield Rd., Silv	er Snring	. MD 20904
	Sta	te		egistrar's Signature	i i	5P-1116	.,
	Registr		FFD 1 9 5000	and the last	artis		

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Lois Lillian Henschen 2009 5:13 A M 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Parkville Baltimore 9646 Alda Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 09-02-1937 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Months Hours 1 ☐ M 2 🛛 F Marviand 213-34-9795 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 🔀 No Parkville Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21234 9646 Alda Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify. White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Clerk Credit-Finance Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter E. Gable Ida Krowkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Robin Rogers - Daughter Baltimore, Maryland 21234 9646 Alda Drive 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-18-2009 Timonium, Maryland Dulaney Valley Memorial 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Lice Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Murte disease or condition resulting in death) Due to (or as a consequence of): 0 TONORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of).

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Be Completed

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**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

use as the burial-trar attending physician ó cate has been signed page 2 should be det certificate director,

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 10

Be Completed by Physician/Medical Examiner Certification: To Medical

Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year	
Part II. Other significant conditions	s contributing to death but not resulting in the under	erlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
	1		24a. Was an autopsy performed		
25. Was case referred to medical		26. Place of De	ath (Check only one)		
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing H	dome 5 Nasideno	e 6 ☐ Other (Specify)	
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
3 ☐ Suicide 6 ☐ Could no determine		t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	Physician: To the best of my knowledge, death of aminer: On the basis of examination and/or investigated.				
29b. Signature and title of certifier		29c. License number	29d	Date signed (Month, Day, Year)	

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10F 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Betty E. Hurst **Physician** 9:00 AM 2009 February 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Heritage Meridian Ctr. Dundalk Baltimore Co. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 216-30-0729 Funeral 1 □ M 2 1 F Min. Months Days Hours Aug. 12,1936 Director 72 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County er than "natural", or Items 23a or 28a-f show Edgemere 1 ☐ Yes 2 XNo Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21219 United States 2306 Maple Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ဩNo 14. Bace - American Indian. 11 Marital Status 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🛛 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Western Electric al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Material Handler Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be file of Health and Mental H item 27 is marked oth other traumatic even Be Lewis Alexander Pearl Salefsky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Kenneth E. Hurst (Husband) 2306 Maple Road Edgemere, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 arment of Hi 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 2/14/2009 Middle River, Maryland 4 ☐ Donation neral Solice Lice 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner EMBOLISM Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner PERTENSION that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, nding physician are as the burial THROM BOSIS Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death atten 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 □ Yes 2 of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural 1 Tyes 2 🗍 No 2 Accident ours a er death neral Director filled in by the f 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a **To the Funeral** D

completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie 5

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 11, Year 2009 MARIE **GERTRUDE** HODAK 3:25P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GILCHRIST HOSPICE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1□ M 2□¥ 88 213-18-3845 MÄRYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County BALTIMORE ROSEDALE MD 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 1315 CHESACO AVENUE **APT235** U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify: Specify. 3 XWidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) BOOKKEEPER LAVINO SHIPPING CO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **GEORGE** HICKMAN GERTRUDE (LAPPE) 19a. Informant's Name/Relationship (Type. Print) HELEN HESS/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), $8702\ GERST\ AVE\ PERRY\ HALL$ , MD 2112821128 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY: 2-14-09 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MUDCARDIAL INFARCTION disease or condition resulting in death) Due t/ (or as a consequence of): ATHEROSCLEROTIC CORONARY ANTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) #OSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation

**Physician** /Medical Examiner

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within 24 hours a

filled in by the

completely

Medical

Hospital or Attending

Physician

**Examiner** 

**Funeral** 

Director

Department of Health and Mental Hygiene, important; or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprinent and the nutthed at once.

filed within 72 hours after death with the Maryland

Pages 1 and 2

Baltimore,

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/Medical

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Funeral

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the burial-trans detached s been signed be should be deta page 2 funeral director,

Physician/Medical Examiner Completed by Be Certification: To

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) М 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

D64395

FEBRUARY 11, 2009

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

6565 N CHARLESST, SWITE 209 BACTIMORE, MD 21204 DANIEUE DOBERMAN. MD

State Registrar 31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

32. Registrar's Signature

arks

Amend 16a-b, perFH g888 2/18/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04644 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 15 **Physician** SOPHIE HALPERN 2009 2:53 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) 03/29/1912 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 180-12-2564 96 PA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE TIMONIUM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12230 ROUNDWOOD ROAD 21093 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Delicatessen Elementary/Secondary (0-12) College (1-4or 5+) 0wner **DELICATESSAN OWNER** Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCAR RETTER DORA UNKNOWN permit. Pages 1 and 2 shoul Department of Health and M. Important: if item 27 is marl any Injury or other traumati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar RICHARD HALPERN / SON 8016 UPPERFIELD CT., OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of ARETINGTON CHILDURACE) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MD AMUNO CONG. 02/17/2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. ome 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the diseast of the cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lean /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 ☑ No Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21204 31. Date filed (Month; Day, Year) 6701

Registrar

State

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Dern,

32. Registrar's Signature

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Amend 19a, per Fh G888 2/19/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 16th 20098 **Physician** Jones Harold /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDAIIS LOWN Baltimore tome GENESIS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral №** M 2 F Months 04/21/1948 Maryland Director 219-50-6531 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1**X**Yes 2 □ No Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 14. Race - American Indian 2108 Sydney Ave. 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Recreation 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk William Jones Ruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5421 Channing Road, Baltimore, Maryland 21229 Derrick Jones/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Metro Crematory Inc. 02/21/2009 Baltimore, Maryland 21. Signature of Funeral Se Licens 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave, Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Enterococcus, Seudomonas **Physician** 170 n /Medical blood Due to (or as a consequence of): Examiner Star Y C disease na Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician Physiclan/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9∏Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be o Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760, the Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FFR 1 8 2000

SAIMA

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

KHAWAJA

DHMH 17 Rev 1/2001

Registrar

, M.

32. Registrar's Signature

29c. License number

D0058965

Randallstonn

9109 Liberty Road

29d. Date signed (Month, Day, Year)

February 16th 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month **Physician** 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWINGS MILLS
If Under 1 Year If Under 24 Hrs.
Days Hours Min. Baltimore lahoe ircle 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗙 F Director 35 03/04/1973 Maryland 220-84-0734 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show my or other tran "natural" or items 23a or 28a-f show my or other traumatic event, it. "No after Exp. infer must be notified at my or other traumatic event, it. 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Owings Mills 10g. Citizen of What Country? U.S.A. Funeral 37 Tahoe Circle 21117 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 ed other than "natural", or event, the Medical Exami Specify: Black 1 □Yes 2 🛣 No If Yes, Give Year or Dates: Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Operation Preparer Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Michael A. Jones Gladys Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Gladys Moore / Mother 37 Tahoe Circle Apt. E, Owings Mills, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park Ceme. 02/20/2009 | Baltimore, MARYLAND 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licen 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each fine. Approximate Interval Between Onset and Death Esthesione Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician at the burial Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No this certificate 1 □ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 5 Residence 6 □ Other (Specify) After thi 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 04647 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Johnson 2 10 2009 11:35P <sup>M</sup> Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2108 Homewood Avenue Balto If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-12-1926 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M X X Days Hours Min. 83 Director N.C. 219-18-5238 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examples of the notified at Director ty∑Yes 2 🗌 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2108 Homewood Avenue 21218 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed by Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 11th grade N/A Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stad Jacob Fannie Francis Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 Homewood Avenue Balto, MD 21218 Janet Franklin-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 2-16-2009 Randallstown, Md King Memorial Pk 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) filled in by the funeral director, page 2 should be detached 1 ☐Yes 2 MNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 29a Certifier TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Attending 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Newland Romo NAR MD 3512 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 15, аМ THELMAN **JOHNS** February 9:59 JOSH 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Arcola Health & Rehabilitation Ctr. Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours 1 ☑ M 2 □ F Director 723-14-6827 July 12, 1927 Virginia 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examination must be multified at 1√Xes 2 No Director MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 20708 9254 Cherry Lane, Unit 15 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XXes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter Grade 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McGinnis Johns Bertha Branham ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 9254 Cherry Lane, Unit 15 Laurel, Maryland 20708 Mary F. Johns spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 remation 3 ☐ Removal from State West Arundel Crematory 2/17/09 4 ☐ Donation 5 ☐ Other (Specify) ODenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cerebrovascular Disease vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Hypertension, Malnutrition, Cerebrovascular Accident cate has been signated by page 2 should b 2∑No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼Mo Encephalopathy 24a. Was an autopsy performe certificate 2 **XX**0 1 ☐ Yes Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 X Mursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 💢 💢 o ပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 53367 February 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, Suite 117 Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For	lease Type or Pr State of N		/ Depa	rtment of H	lealth and N	_	•	gible.	n L	649
	Physici	an	State     Registrar  1. Decedent's Name (First, M.)	Middle, Last)		Cei	tificate of	Death	2. Date of De Month	Day	Year	3. Time of 4:52	Death
	/Medic Examir			tution, give street and number Adventist Hos	spital		4b. City, Town, o	r Location of Death  Rockvill  If Under 24 Hrs.		Mon	nty of Death	У	
ſ	Funeral Director		5. Social Security Number  095-44-1069 Usual Residence of Deceden	1⊠ M 2□ F	Age (In yrs. las	Yrs.	Months Days	Hours Min.	(Month, Da	7/1950	9. Birthp Coun NY	lace (State of try)	Foreign
the Maryland	28a-f show notified at	Director	10a. State 10b. Con  MD Mo:  10e. Street and Number	unty ntgomery		Town or Lo				10g. Citizen o		0d. Inside Cit  1   Yes  trv?	-
<b>30</b> s after death with the Maryland	Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notitled at	by Funeral Dir	1801 Researc  11. Marital Status  1 □ Never Married 2 ☑  3 □ Widowed 4 □ Divo	12. Was Decede Armed Force 1 2 Yes 2 If Yes, Give	s? No	1	20850	- Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Unite	ad Stat	ces an Indian, etc.	
21215-0036 within 72 hours af	iene. r than "natural' the Medical Ex	Completed b	15. Dece	edent's Education lighest grade completed)		16a. Decedent's Usual Occupation     (Give kind of work done during most of working life. DO NOT use retired)  None				16b. Kind of Business/Industry None			
aryland 2 should be filed	and Mental Hygis is marked other raumatic event, th	To Be C	17. Father's Name (First, Mic Girard Jaec 19a. Informant's Name/Rela	ger				18. Mother's Nam  Gloria  and Number or Ru	(Unknow	wn)		Codal	
Ore, N	° = 5	4	Grace M. Jaec 20a. Method of Disposition		ate <i>cer</i>	254 ce of Disponetery, crei	40 Paine sition (Name of matory or other pla	St. Dama:	scus, M Date Feb 16	D 20872	2 – on - City or To	wn, State	
<b>Baitimore,</b> permit. Pages 1 a	Department Important: any injury oonce.		4 □ Donation 5 □ Oth  21. Signature of Funeral Set		Che	2	ake Crema 2. Name and Addre Rapp Fune 933 Gist	ess of Facility ral & Cren	2009 mation Serer Sprin	ervices	ville, yland 2		na
<b>7</b> /	ysician Medical caminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CARDIAG ARRYTAMIA  Due to (or as a consequence of):  Sequentially list conditions									Approximate Interval Bett Onset and E	ween
<b>68 / 60,</b> ifficate be executed	ng physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any cause in men at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	SEVEN as a conseque SEVEN as a conseque GIZM	ence of):	SEPSIS OSITIVE		(				
. <b>Box</b> death cert	e attendii d for use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	s decedent pregnant to the past 12 months?  I yes 2 \( \) No \( \) No \( \) \(								-	Year
Ja ta	been signed by the s should be detached	ed by Pł		EGVAL FAIL	NRE	_	nderlying cause gi	ven in Part I.	1	tobacco use o	/	ne cause of d pably 4 □ U	
Vital Records, sician: The law requires the	ite has	Completed by	MULTIPL						per 1⊡ Yes	opsy formed? 2 No	tb. Were auto prior to co death? 1 ☐ Yes	mpletion of ca	available ause of
Division or Vital To the Hospital or Attending Physician:	after death. <b>Director:</b> After this certii I in by the funeral directo	ation: To Be	2 ☐ Accident in	Hospital: 1-1 Inp. 28a. Date of (Month, prestigation)	oatient 2 E Injury Day Year)	R/Outpatie 28b. Time o Injury	of 28c. Inju Wo	26. Place of Deather: 4  Nursing Hury at ork?  Yes 2 No	ome 5 Res			iy)	
DiVIS	urs after de eral Directo filled in by th	Certification:	4 ☐ Homicide de	etermined 28e. Place of building	, etc. (Specify)		reet, factory, office		City or To	(Street and Number, State)			iber,
To the Hos	within 24 hours after d <b>To the Funeral Direc</b> completely filled in by	Medical		dical Examiner: On the bas and manne	is of examination is stated.	on and/or ii	nvestigation, in my	opinion, death occu	urred at the time	e, date and pla	ce, and due t	o the cause(s	
1	(1)	,		erear who completed cause	of death (Item :	23a) (Type	Print)	00444	78	2,	113/0	208	150
	St Regist	ate trar	FISEITATISI 31. Date filed (Magnipulay,	18 2009 De 18	jistrar's Signatu	D 99	alled and a	se number  OOGYY  ALCENTISE	e Brive	Koc	KVILLI	E ME	>

FEB 1 8 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $oldsymbol{\epsilon}^{\ \ \ \ \ \ \ \ }$ For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** O 9 /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death street and number) 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Security Numbe 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 21509 Days Hours Min Yrs June 8, Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic ayant, the Medical Examinar must be notified at Mr ahnsvi 1 ☐ Yes 2 XNo Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 228 15 23a w Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Ia markad othar than "natural", or Itams 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank A. Chesno Elizabeth Veritas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any injury or other tra Diane Tichnell Daughter 15 Hillton Place: Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2/17/2009 Atlantic Crematory Glen Burnie, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee majosu Funeral Home of Catonsville, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omplic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 Other (specify) 4☐ Pregnant at time of death P.O. the be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 2 No 3 Probably 4 ☐Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 🗌 Yes after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35106 16 address of person who completed cause of death (Item 23a) (Type, Print) 35 Milkshake Lane, Jennifer Ruddle-Frey Annapolis, MD 21403 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

182009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5perFH G888 2/18/09 WS State of Maryland Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2256 M **Physician** STEVEN THOMAS JACKSON 2009 2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Arundel Medical Anne unde Polis nna If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days and NONE Director Mary Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Prince 1 Tyes 2 Tolk MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Kelsey Lane 20715 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 □Yes 2 No Specify. و ک 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jackson Steven Wade Diane Marie Murray ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2402 Kelsey Lane Bowie, Md 20715 19a. Informant's Name/Relationship (Type. 2402 Kelsey Lane Jackson Steven Department of Health Important: If Item 27 any Injury or other trong. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 2/21/2009 4 Donation 5 Other (Specify) Clinton, MD 21. Signature of Juneral Septime Licens 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 16 1001 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine y physician and is the burial-trans Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐Yes 2 5 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ■ npatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) after death.

Director: After the in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 L'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760 🛇

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Health an

Baltimore, Maryland 21215-0036

Medical

ARHELES

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Argeles

Year)

FEB

31. Date filed (Month, Day,

D0063471

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 12:00 DM 2009 OVES onvan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bal timore 6000 Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be a collided at once. Yes 2□No Director TIMOR 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Completed by ₩idowed 4 Divorced Jones, Dellone 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ochodry (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) ame (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto ND 21239 20b Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltinore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee T0 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner ension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi signed by the attending physician and I be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □Yes □No 9 □ Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 2 TNQ ER/Outpatient 3 DOA 1 Inpatient မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D0062735

Registrar

State

5601

och Raven Blvd, Baltmore,

Name and address of person who completed gause of death (Item 23a) (Type, Print)

Jonna

FEB 1 8 2009

Aparna January (Month, Day, Year)

MD

32. Registrar's Signature

			/
Amend	#8 per FH G888	2/20/09 TT	Ensure All Copies Are Legible
	Please Type or	Print in Black Indelible Ink.	Ensure All Copies Are Legiple
For	State of	of Maryland / Department of H	ealth and Mental Hygiene

			For State Registrar	State of Marylar			nt of Healt ate of Dea			giene Reg. No.			
Ø	Physici	an	1. Decedent's Name (First, Middle, Las	,					2. Date of De Month	ath Day		ır	. Time of Death
	/Medic	al	Hyang Ha Kang  4a. Facility Name (If not institution, give	street and number)		4b. Ci	ty, Town, or Locat	tion of Death	2	40.	County of De	•	6 A M
^			Lorian Nursing				Columl				Howa		
	Funeral Director			7. Age (In yrs.		If Und Month		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da 9/17/ <del>2</del>	th 1y, Year) <del>009</del> 1	928 <sub>Ko</sub>	Birthplace Country) rea	(State or Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo							10d.	Inside City Limits
	e Man	ctor	Maryland Howar	d	Columb	ia							X Yes 2 No
	with th	Director	10e. Street and Number 6334 Cedar Lane			10f.	Zip Code				zen of What		
	death me 23	Funeral	11. Marital Status	12. Was Decedent Ever in L	J.S. 13.	Was De	21044 cedent of Hispanic pecify Cuban, Mex	c Origin? (Sp	ecify Yes or No		ited S		
036	filed within 72 hours after death with the Maryland Hygiene. Whet than "natural", or terme 23a or 28a-f show with the Medical Ezamir at must be modified at	þ	1 Never Married 2 Married 3 XXVidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 <b>∑</b> No If Yes, Give Year or Dates:			oecify Cuban, Mex 2X No Spe		Rican, etc.)		Black, W.		
ည	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>	(Give	kind of	sual Occupation work done during	most of work	ang	16b. Kii	nd of Busine	ss/Indust	ry
2	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			emaker			0.	wn Hom	_	
ק מ	should be filed within 72 hc id Mental Hygiene. marked other than "natur matic event, the Medical	Be Co	17. Father's Name (First, Middle, Last)			1101110	1	nother's Nam	e (First, Middle			e	
<u>Xar</u>	should be nd Mental marked o	ToE	Tae Cho					Choon					
Maryland 21215-0036	2 a a a	n i	Joon Kang — S				oss (Street and Nu .ba Road,						
	s 1 and 3 if Health Item 27 other tr		20a. Method of Disposition	1	Place of Dispo cemetery, crer	sition (A	lame of		Date		cation - City		
Ē	Pages ment of I ent: If Its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hernoval from State		•	ematory	2/18	/2009	G1er	n Burn	ie,	MAryland
Baltimore,	permit. Page Department Importent: If eny Injury or once.		21. Signature of Funedal Service Location	Soharun			and Address of F Washingt		-				Home, Inc 21075
Ξ		Illimediate Cause (Final											
1 1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			د	CARDIE	ovasc	ULAR '	DisE	ASE	-	set and Death
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.02	P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):								
	secute n end al-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):								
28760	ficate be executed g physicien end is the burial-transit	edical E		d									
_	- CD -		IF FEMALE:				<u> </u>						
Box	eath certiff attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of	aldeath 3[	Ectopic Other	pregnancy			2	23d. Date of o Month	delivery Day	y Year
д. О	by the de	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
Division of Vital Records, F	The law requires that the death certive has been signed by the attending tage 2 should be detached for use	þ	Part II. Other significant conditions or	ontributing to death but not re	sulting in the u	nderlyin	g cause given in P	Part I.					ause of death?
eco	law re as ber	Completed							24a. Was		24b. Were	autopsy	findings available
<u>e</u>									perfo 1 ☐ Yes	ormed?	death 1 🗆 Y	?	
Ĭ	ysician: is certific director,	To Be	25. Was case referred to medical examiner?	Hospital:	] ER/Outpatier	nt 3[]	Other		th (Check only only one 5 In Resi		E MOther (S	000/6/1	
0	ding Phy h. After thi tuneral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?		28d. Describe			pacity)	
Sio	Attending Physician: r death. ector: After this certific by the funeral director.	catic	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗌 Yes	2 🗌 No					
N	in Die	Certification:	4 Homicide determined	building, etc. (Speci	<i>fy)</i>				28f. Location ( City or To	wn, State,	)		
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier  (Check only one)  2 Medical Exam	y <b>sicien:</b> To the best of my kn i <b>iner:</b> On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurre vestigati	ed at the time, dat on, in my opinion,	te and place, , death occur	and due to the red at the time,	cause(s) date and	and manner place, and d	as stated lue to the	d. e cause(s)
<b>.</b>	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	1		- 2	29c. License numb	ber		29d. Dat	e signed (Mo	onth, Day	Year)
			Kanky Chelony	1 ms			D0060	052		FEBR	LUARY	17,	2009
			30. Name and address of person who of PANKAT KHETER 1				GIARTH		OCKEY	(1/11		۸۸ -	-210.20
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	es?	J. 17/17	, , _				- 10 -	, -, 0
	Registr		ren a O /USB	KIND OF THE STATE	75.00 GAP GA	min share							

Amedn #7 per Fh g888 2/18/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland / De <i>C</i>	partment of F ertificate of	lealth and N <i>Death</i>	∕lental Hygi Re	ene g. No. 2009	04654
	Physici /Medic		Decedent's Name (First, Middle     ELKA	le, Last)	KUKELYANS	KY		2. Date of Death Month FEBRUAF	Day Year	3. Time of Death 1:00 P M
	Examir		4a. Facility Name (If not institutio		r)		r Location of Death		4c. County of Death	
	ì			FUTURE CARE			STERSTOWN		BALTI	
	Funeral Director		5. Social Security Number 213-25-7870		age (In yrs, last birthda 4 95 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 04/30/19	Year) 9. Birth Cou	place (State or Foreign ntry) UKRAINE
	aryland show	_	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 No
	he Ma	Funeral Director		TIMORE	RE	I STERSTOWN		10	g. Citizen of What Cou	
	with t	늅	10e. Street and Number 12404 PRESERV	E MAY		10f. Zip Code	21136	10		nu y :
	eath	era	11. Marital Status	12. Was Deceden	t Ever in U.S. 1			ecify Yes or No-	USA 14. Race - Ameri	can Indian.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Model Eventher rules to puffled at	þ	1 ☐ Never Married 2 ☐ Mar 3 🛱 Widowed 4 ☐ Divorced	ried Armed Forces	No I	3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 21 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	etc. ITE
5-0	72 ho 'natur	etec	15. Deceder (Specify only highe	nt's Education est grade completed)	(Gi	cedent's Usual Occup ve kind of work done	durina most of work	ing 1	6b. Kind of Business/Ir	ndustry
121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 2+	r 5+)	DO NOT use retired	d)		COVEDNMEN	т
	filed v Hygie ther t		17. Father's Name (First, Middle,			CHEF	18. Mother's Name	e (First, Middle, M	GOVERNMEN  (alden Surname)	
Maryland	2 should be filed w and Mental Hygie is marked other t raumatic event, th	To Be	ZAELIK	,	BUDILOV	SKY	ι	JNKNOWN	UN	KNOWN
ary	shou and N s mar	-	19a. Informant's Name/Relations	ship (Type. Print)	19b. Ma	iling Address (Street	and Number or Rur	al Route Number,	City or Town, State, Zi	p Code)
	1 and 2 Health a em 27 is		MICHAEL KUKEL	YANSKY / SO	N 1	2404 PRESE	RVE WAY,			21136
lore			20a. Method of Disposition 1 XBurial 2 ☐ Cremation		cemetery, c	position (Name of rematory or other place)	ce)		Oc. Location - City or T	
Baltimore,	in in it		4 □ Donation 5 □ Other (S		BALIIM	ORE HEBREW 22. Name and Addre			REISTERSTO ON & BROS.	-
ä	permi Depar Impor any ir		175	The	,		TERSTOWN	ROAD - P	IKESVILLE,	MD 21208
			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cause tonly one cause on each	ed the death. Do not line.	- /	Λ. /	1	st,	Approximate Interval Between Onset and Death
200	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Mid >	tues 6	Swent	U	4	noun
	/Medical Examiner		roodking in dodary	Due to (or a	is a consequence of):	ð				
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	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or a	s a consequence of):					
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687	tificate g phy as the	ledical		u						
P.O. Box	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ey .		23d. Date of delive Month	very Day Year
	res that signed b	by Ph	Part II. Other significant conditi	ens contributing to death	out not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w require s been sig should b	led !		1 Trial	15			1 ☐ Ye	s 2 <b>⊒+1</b> 00 3 □ Pro	bably 4 Unknown
of Vital Records,	law r has be	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
a F	ictan: The law certificate has I ector, page 2 s							perform 1 □ Yes 2	led? death? ☑No 1 ☐ Yes	2 □ No
Z.	Physician: this certific	Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 🕍 No	Hospital:		iont 3 🗆 DOA Oth		h (Check only one		
of	ding Phys h. After this funeral dir	5.5	27. Manner of Death	28a. Date of Ir		of 28c. inju	4 LAI Nursing Ho	ome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spec	ify)
ion	nding ath. r: Affe e fun	atio	1 🕅 Natural 5 🗌 Pendir 2 🗎 Accident investi	ng (Month, E igation	Day, Year) Injur		k?  Yes 2□No			
TO NOT STATE OF THE PROPERTY O						street, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C		ng Physician: To the best Examiner: On the basis and manner	of examination and/o					
	To the within comp	M	29b. Signature and title of certifie	A M	ho	29c. Licens		7	2/ (6/o	Day, Year)  7  1 U205
			30. Name and address of person	who completed cause of	death (Item 23a) (Typ	e, Print)	176 6	Control	T	1 21725
	Sta	ato.	31. Date filed (Month, Day, Year)	32. Regis	Strar's Signature	neen 18	118 0	een	nee le	1008
	Regist		FFR 1	8 2009	was A.	barked				
			1 1 1			/				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 12, 2009 **Physician** JOSEPH JOHN LEHNER, JR. 11:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DUNDALK BALTIMORE 711 WISE AVENUE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 12-22-1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 79<sub>Yrs.</sub> 216-28-5562 1 ☑ M 2 🗆 F MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat result be notified at once. 1 ☐ Yes 2 ☐ No Director MD BALTIMORE DUNDALK 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or: 21222 U.S.A. 711 WISE AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates 1 9 5 1 − 5 3 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. WHITE Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE BETHLEHAM STEEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GENEVIEVE** (FARRIS) JOSEPH JOHN LEHNER, SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GEORGIA LEHNER/WIFE DUNDALK, MD 21222 711 WISE AVENUE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition KOBurial 2 Cremation 3 Removal from State HOLLY HILL MEMORIAL 2-16-09 MIDDLE RIVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses ROSEDALE, 1211 CHESACO AVE 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INC 1 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) slcian and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Jeborah 6730 GALLO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tems 18,19a per inf g888 2-25-09 vt State of Maryland / Department of Health and Mental Hygiene amend item 12 per in g888 2-27-09 vt Reg. No. 200 Reg. No. 2009 for State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Year A M Philip John Leicht Februar 13, 2009 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Yε POINT Maryland Health 5. Social Security Number 7. Age (In yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Days Hours Min 72 216-26-7290 10/22/1936 MD Director Usual Residence of Decedent Vame Known to Physician: Leicht, Philip 10h. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show coust be notified at Director 1 ☐ Yes 2 No MD Dorchester Hurlock 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 6552 Cabin Ridge Road 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [Ayes 2 □ No If Yes, Give Year or Dates: 1950 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, its Modicel Extra 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔄 No Specify: White Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metal Fabrication Elementary/Secondary (0-12) College (1-4or 5+) Draftsman 18. Mother's Name (First, Middle, Majden Surname)
Schlauch Be 17. Father's Name (First, Middle, Last) Adam Philip Leicht Marie A. ပ 19a. Informant's Name/Relationship (Type. Print)
Philip Alien Leicht/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6772 Susquehanna Trail York, PA 17403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 17 Chesapeake Crematory Inc. 2009 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Respiratory **Physician** )nknowk /Medical Due to (or as a consequence of): Examiner Cancer Jahrown Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last una Examiner Line to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number PA State 29b. Signature and title of 29d. Date signed (Month, Day, Year) MD 726921 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 VA Maryland HEalth Care System, Perry Point, MD Bullock, MD. VA Nam.
32. Registrar's Signature Deborah 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LASKER 1:15 P M MIRIAM FEBRUARY 16 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 9. Birthplace (State or Foreign Country) 8. Date of Birth 02/06/1916 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F Days Hours 93 116-30-1487 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marytand 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County , or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** OWINGS MILLS BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21117 4606 SPRINGWATER COURT, #B 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: β 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7?
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any Injury or other traumatic event, It a Medie once. College (1-4or 5+) Elementary/Secondary (0-12) PROFESSIONAL GIRL SCOUT SOCIAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SCHWARTZ ANNA ၉ SAMUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4606 SPRINGWATER CT., #B, OWINGS MILLS, MD 21117 MARTIN LASKER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CARROLL CREMATION INC 02/17/2009 HAMPSTEAD, MD 4 Donation Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Tschemia small Bowal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. Medical Certification: To Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar P 9000

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 04658 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 15, 2009 Mia1 10:30 PM Kenyon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Y Dec. 24, 5. Social Security Number 6. Sex 14 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours 1975 241-47-5272 33 Director North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits **Funeral Director** 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2044 Fort Davis Street, SE, Apt.102 20020 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐Yes 21☑No Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Executive Director Princeton Review 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Ronnie White Lynette Mial 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynette Bingham 4212 Queenbeth Drive, Greensboro, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial\_ 2 ☐ Cremation 3 ☐ Removal from State Forest Lawn Cemetery | 2-21-09 4 ☐ Donation 5 ☐ Other (Specify) Greensboro, NC 21. Signature of Funeral Service Licenses Perry J. Brown Funeral Home ellem 909 E. Market St., Greensboro, NC 27420 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** AIDS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** METASTATIC KAPOSIS SARCOMA TO LIVER & LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) nding physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 5 ☐ Other (specify) signed by the a d be detached fi 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ANASARCA 1 ☐ Yes 2 ☐ Alo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performe 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To uneral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred **Division** 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A 1 ☐Yes 2 ☐No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Dupanich Bru D 0065 485 2/16/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, MD 1500 Forest Glen Rd., Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

of Vital Records.

			For State	State of Maryla		artment of H			giene Reg. No.2 N N	9 01.659
			Registrar  1. Decedent's Name (First, Middle, Last	)				2. Date of De	ath	3. Time of Death
T. Wallet	Physici /Medic		Sysan		[1]	essin		Febru		cog 1734 M
	Examin		4a. Facility Name (If not institution, give The Johns Hopkins Ho	•	•	4b. City, Town, o	City		್್ County of E	Death
Īs	Funeral Director		5. Social Security Number 6. Se 234-94-9597 1.1	7. Age (In yi	rs. last birthday)  1 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birt n. (Month, Da 3 – 2	7 - 1957 9.	Birthplace (State or Foreign Country)  MD
	land low t		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Mary Ba-f sh iified a	ctor	MD N/	Α	Baltim	ore				1X Yes 2 □ No
	h with th	Funeral Director	10e. Street and Number 447 N. Linwood	Avenue		10f. Zip-Code 212	04		10g. Citizen of What USA	•
980	ours after death with the Marylan ral", or items 23a or 28a-f show Examiner must <u>be notified at</u>	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give X Year or Dates:	'	Was Decedent of F f Yes, specify Cub. I ☐ Yes	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		American Indian, Vhite, etc. WHITE
21215-0036	vithin 72 h ne. han "natu e Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of vi	vorking unk	16b. Kind of Busin	ess/Iridustry unk
	12 should be filed with h and Mental Hygiene. 7 is marked other thar traumatic event, the M	Be	12th grade  17. Father's Name (First, Middle, Last)  James Lewis B	51, 22				Name (First, Middle	,	
Maryland	s 1 and 2 should if Health and Mei item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (7)  Jeffrey Arthu						er, City or Town, State	
	1 and Healt tem 2		20a. Method of Disposition	201	b. Place of Dispo	sition (Name of	\	Date	alto, MD 20c. Location - City	or Town, State
om.	Pages nent of I ant: If ite ury or o		Burial 2 Cremation 3 4 Donation 5 Other (Specify,			on Fore	st 2-	20-2009	Owings	Mills, MD
Baltimore,	permit. Pages Department of Important: If it any injury or once.	80 9	21. Signature of Funeral Service Licens	ee	22	Name and Address 1101 E		March E h Avenu	ast F/H e Balto,	MD 21202
3			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	ne cause on each line.			ng, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cardiac  Due to (or as a cons	Arres 1					
	Examiner	<u>.</u>	Sequentially list conditions,	b. Hyperter						
	ted insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dur o (or as a cons Asthma	sequence of):					
Ô	sate be executed ohysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
8760	ifficate be g physici as the b	edical		d						
. Box 68	death cert e attendin ed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pres 1  Live birth 2  F 4  Pregnant at time of 9  Unknown	etal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of Month	f delivery Day Year .
, P.O.	es that the de igned by the a be detached	by Phy	Part II. Other significant conditions co	ntributing to death but not	resulting in the	ınderlying cause g	iven in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
ords	v requires t been signe should be	ted t						_ 1 🗆 `		
Division of Vital Records,	The lavate has	Completed						24a. Was autop perfo	osy prio rmed? deat	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	Physician: Tr this certificate eral director, pa	o Be	25. Was case referred to medical examiner?  12 Yes 2 \( \subseteq \) No	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA Oth	or:	eath (Check only on Home 5 Resid	,	Specify)
on of	ding Phy. h. After this funeral o	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wor	ry at	1	now injury occurred	
Divisi	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - Al building, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location ( Cify or Tow		or Rural Route Number,
	Hospital 24 hours Funeral I	edical (		rsician: To the best of my kiner: On the basis of exam and manner stated.						
	To the I within 2 To the I comple	Med	29b. Signature and title of certifier	and marrier stated.		29c. Licens	e number		29d. Date signed (M	Ionth, Day, Year)
			D. Dough (	Silbert 2	0.0	RE	5-000		February	09,2009
	1		30. Name and address of person who	bert. D.O.	Item 23a) (Type,	Print)	60	0 North Wo	lfe St. Balti	more, MD, 21287
	Sta Regist		31. Date filed (Month, Day, Year) FFR 1 8 2003	32. Registrar's Sig	nature	Ked			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Day **Physician** Charles M. Mitchell, Jr 2009 9:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 901 Cherry Hill Road Baltimore N/A Apt If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 09-5-1944 Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 64 XXM 2□ F MD **Director** 219-40-5557 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the two call Exament in the mailtest at Director 1X Yes 2 ☐ No N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 21225 USA 901 Cherry Hill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 ∐Yes 2 No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2/☐No Specify: Black ģ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. United Moving Co. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12th grade N/A permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Charles M. Mitchell, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 158 Mary Parker-Devoted 901 Cherry Hill Road Balto, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Carmel Cemetery2-18-2009 Balto, MD 21. Signature of Fur eral Service 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute milocardial infarction <u>30 minutes</u> disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 11 years Diabetes Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a su isaquence of) burial-transit Exami ang Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🖾 No 2 🗆 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

filled in by the funeral To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Registrar

ca

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miya Paterniti, Johns Hopkins Hospital, woo North worfe street, Baltimore, Manjand 21287

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Mina Polit, medical doctor

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Lonnie Mack, Jr 2.02 P 200 4a. Facility Name (If not institution, give street and number 4b. City, Town or Location of Death 4c. County of Death Agrila Ba HOSPITA NA Mus 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 12-21-1925 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1**X** M 2□ F S.C. 238-30-1090 83 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits 1 XYes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2725 Walbrook Avenue Apt 703 21216 S Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☑Yes 2 ☐ No 1 Yes 2 ☐ If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 9th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lonnie Mack, Sr Bessie Boyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie Mack-Brother 110 Scott Road Front Royal, VΑ 22630 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 2/24/09 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East Mla 1101 E. North Avenue Balto, 2102 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (10 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1∐Yes 2. 🗖 No 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1√10 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

cal

29a, Certifier

(Check only

31. Date filed (Month, Day,

29b. Signature and title of certifier

A. Ahma

Year)

item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, It of Madical Examiner must be notified at

s 1 and 2 should be filed wi f Health and Mental Hygier item 27 Is marked other th

permit. Pages 1 and Department of Heal Important: If item 2

**Physician** 

/Medical

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Baltimore, Maryland

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State Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type,/Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04662 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 , **Physician** EERUARY Ž009 0 02:20FM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** owson imore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Sex 1 M 2 □ F Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 216-20-914 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov traumatic event, the Medical Examiner must be notified at Yes 2 No Funeral Director MP. permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural" any injury or other traumatic events. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 U. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ed Forces? Yes 2 NoWAVe 9 1 Dres 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TE GRAD Non Mc DonAld ၉ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ONA 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition wingsMills 5 ☐ Other (Specify) ner Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of):
URINARY TRACT **Examiner** INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ACUTE MYOCARDIAL INFARCTION 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s his certificate ha autopsy perform 1 ☐ Yes 1∏Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient this 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Death 1 X Natural 2 Accident Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year 5 Pending investigation death. ours after death.

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To the Funeral D

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

M. D. 7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

D37254

TOWSON, MARYLAND 21204

D

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 04663 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles William Mareck Feb. 12. 2009 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Parkville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0ct. 27, 1925 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**)√**(M 2 □ F 83 Oct. Mary land Director 220-20-4990 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examinar must be redified MD Baltimore 1 ☐ Yes 2XXNo Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. Apt. 2601 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo If Yes, Give Year or Dates: WWII. Specify: þ Specify: 3XXWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglene Important: If item 27 is marked other that any injury or other traumatic event, Iral once. Purchasing Agent Johns Hopkins Univers. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mareck ٩ Mildred Reeder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Shauck / Daughter 131 Ravenswood Ct. Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 2/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Rd. KW Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic DION Cancer (Adenocarcinama disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. attending physi for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) ed by the a Records, P.O. 1 □Yes 2 □No 9 Unknown חונים עונים ניסרווווכמנפ has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ₩No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkville, MD Z1234 Dixon Blud tosha Walther 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar Barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Α Antonietta Nancy February 12, 2009 430 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 15401 Laurelton Drive Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 24, 1954 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X F 212-68-2116 Director Washington, DC Usual Residence of Decedent fshow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 No Prince Georges Maryland Laurel with the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 20707 USA and 2 should be filed within 72 hours after death : lealth and Mental Hygiene. 15401 Laurelton Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta Maria Lostraco ပ Salvatore Marinucci 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emilio Mancini- husband 15401 Laurelton Drive, Laurel, Maryland 20707 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
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any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2/16/2009 Silver Spring, Maryland 21. Signature of Funer II & rvice Licensee 22. Name and Address of Facility Fleck Funeral Home, INC M01234 7601 Sandy Spring Rd, LAurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transi and Due to (or as a consequence of) Box 68760 physiciar Physician/Medical as the attending nse ' IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 5 ☐ Other (specify) Ö the 9 Unknown 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Congestive Heart Failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been The law r 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an End Stage Renal Disease certificate has autopsy performed? 1 Yes 2 No page 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2X No After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation death. i Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) the

State Registrar

Carroll Ave, Suite 480, Takoma Park 7610

29c. License number D 0.6367 | 29d. Date signed (Month, Day, Year) | 2/12/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALI Ghorbanimis

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar's Signature acto

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			State of Maryland / Department of Health and Me	ental Hygier	ne	01000
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	Physici /Medio		Christine K. Macklin F	ebruary	15, 2009	3. Time of Death 3:15 A M
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	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day Yea	9. Birthpl	lace (State or Foreign try)
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	/ / /	110	Od. Inside City Limits
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	and 2 s ealth an n 27 is I		WILLIAM MACKLIN 3617 TEMPHAR RO	Hayte Number, City Yi Rawa'a'	15/10WD, State, 210	D. 21133
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Balti	permit. Departr Importa any inju		21. Signature of uneran Servic Licenses  Name and Address of Facility  (10,70)  (25)	eral Home	e P.A. S. MO 216	229
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock/or/heart failure. List only one cause on each line.  Immediate ause (Final	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a missequence of):			5years
		ner	Sequentially list conditions, if any, leading to immediate course. Find Uncortying.  Due to (or as a consequence of):		-	
ć	ficate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
58760,	ficate be physicial from the burner	edical	d			
P.O. Box (	Attending Physician: The law requires that the death certificate articath.  After the this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1		23d. Date of deliver Month [	ry Day Year
G,	iires that t signed by d be detac	by Ph		23e. Did tobacco	o use contribute to the	cause of death?
ord	w require been si should b				No 3□ Proba	ably 4 🗌 Unknown
Division of Vital Records,	sician: The law certificate has b irector, page 2 s	Completed		24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of
<u> </u>	nysicia nis cert directe	o Be			6 ☐ Other (Specify)	)
o uc	ding Ph h. After thi funeral	ion:	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury at Work? 1 Natural 5 Pending M 1 Pes 2 No	d. Describe how inju		
Division	Pospital or Attend 24 hours after death Funeral Director: , etely filled in by the f	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street a City or Town, Sta	and Number or Rural ite)	Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C		d due to the causer at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
_	To the within To the compl	Me	29b. Signature and titlerof certifier  29c. License number	29d. D	Date signed (Month, D	ay, Year)
	10		D35254	2-	17-09	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Carolo Milleum 9 900 Caton Que Br	Tet mo	ne mo	2/229
	Sta Registra		EED 4 0 0000 6 4 4			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G889, 3/17/09, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 04667 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Physician Month **q**\_ 2:307 M irdelia Aline Musby /Medical 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore nder 1 Year | If Under 24 Hrs. Memorial nion If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 214-62-8701 56 Yrs. 9.1452 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show 77 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Moderal Evan, the first for  of the fi Baltimore Director 1 Vos 2 No M10g. Citizen of What Country 10e. Street and Number J.S. 21239 Beaumont 1206 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐Ne Specify: φ Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hupe ( are giver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vinsor ) ohn Naomi 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 1206 Begunont Battmore MD 21239

20c. Location - City of Town, State Anquinette SUA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Deurial 2 Cremation 3 Removal from State 2.16.2009 Baltimore, MI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vougnn C. Greene Funeral Services 21. Signature of Funeral Service Licensee AdBallimore, MD 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a configuence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, physician Physician/Medical the oding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death
☐ Unknown Month Day Year 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Onknown obail 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 □ ER/Outpatient 3 □ DOA 1 🔲 Inpatient Medical Certification: To After this the funeral 27. Man ⊀r of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending nours after death.

neral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28266. 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 5010. YORK Rd, Belto. MD. 21212 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 R. Neal Jr. 2:45 Phillip 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 XM 2 ☐ F Director 52 01/19/1957 220-74-2380 Usual Residence of Decedent Maryland with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show ir than "natural", or items 23a or 28a-f sho 1 Yes 2 □ No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 2606 Violet Avenue 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify Black 1 ☐Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Custodian and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic evonce. Dianne Gamble Phillip Ronald Neal Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Violet Ave., Baltimore, Maryland 21215 Anita Neal / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/23/2009 Baltimore, Maryland Arbutus Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral SerMce Licens 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. He ke Enceptorally ue to (or as a consequence of disease or condition resulting in death) /Medical **Examiner** h Poute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-trans thypotension that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial P.O. Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Year Day 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ HIV 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Hospital or Attending P 24 hours after death. Funeral Director: After t 28d. Describe how injury occurred Certification: Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

Ramela Damisse HD
31. Date filed (Month, Day, Year)

1. Do-see HD

FFB 1 8 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Singi Hespital of Baltimore

32. Registrar's Signature

29c. License number RESONO

2401 W. Belvedere Ave, Bilkmare, HDZIZIS

29d. Date signed (Month, Day, Year)

February 14, 2009

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene   - State
95			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physicia /Medic	_	ElizaBETH PIERSON FEBRUARY 15 2009 338 PM
- Contraction (1997)	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  13.1 h. 20.2 City
	Funeral		Sinaj Hospital of Baltimore (Saltimore)  5. Social Security Number  6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or Foreign Gountry)   1   M 2 1   M 2 1   M 2 1   M 2 1   M 2
	Director		218-22-2457 1 M 25 82 Yrs. Month's Days Hous Will. 12-4-1926 Hary and
	yland how at		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Ba-f sl	Director	10e. Street and Number  10g. Citizen of What Country?
	hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notified at	I Dir	3737 Clarks Lange Out 401 21215 U.S.A.
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
36	s after	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give (1 □ Yes 2 No Specify: Specify: (1 □ Yes 2 No Specify: Specify: (1 □ Yes 2 No Sp
5-0036	2 hour	ted k	15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry
21	within 72 ene. than "na' h• Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+)
d 21	filed w Hygier other th		12   Supervisor (Sovernment)  17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)
lan	ould be filed Mental Hygi arked other atic event, t	To Be	unknown Catherine Jefferson
Maryland	2 should and Men is marke raumatic		19a Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 () 1
_	iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition    April
Baltimore	oermit. Pages 1 a Department of Hes Important: If item any Injury or othe once.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Sérvice Licenses 22 Name and Address of Father was Service P.A.
<u>—</u>	827 2 2		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
2	Physician		shock, or heart failure. List only one cause on early line.  Immediate Cause (Final
8	/Medical		disease or condition resulting in death)  a. Self 1990 and 5 aarys  Due to (or as a consequence of):
	Examiner	<u>_</u>	if any leading to immediate  b. Severe COPD  Due to (or as a consequence of):
N	xecuted and Il-transit	xaminer	b.  Due to (or as a consequence or):  cause. Enter Underlying Cause (Disease or injury that initiated events  c.
5,0	e exec ian and urial-tra	ш	resulting in death) Last  Due to (or as a consequence of):
68760	eath certificate be e attending physician for use as the buria	Completed by Physician/Medical	d
Box 6	n certifi inding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery
	ed for u	sicia	in the past 12 months?  1 Pregnant at time of death 5 Other (specify)  Old Hokeyun
P.0	w requires that the deben signed by the should be detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
rds,	quires n signe ald be	d by	Hypertension 1 Yes 2 HVO 3 Probably 4 Unknown
Records,	@ S N	plete	Rumonary Hypertension  24a. Was an autopsy prior to completion of cause of
E R	The ate h	Com	performed? death?  1 Yes 2 No 1 Yes 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1   Yes   2   16   Was provided by the state of the
o	g Physer this eral dir	n: To	27. Manner of Death  28a. Date of Injury  28b. Time of 28c. Injury at 28d. Describe how injury occurred
sion	Attending r death. ector: After by the funer	atio	2 Accident investigation M 1 Yes 2 No
Division or	or Att	ertific	3 Suicide 4 Homicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
1)	To the within:	Mec	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	. 21 0		Vallah a. Kabzattina RES-000 February 15 2009
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1.3. Taylor A 21-21 M D Siva: Hasartal of Baltimore
	⇔ St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature
	Regist		FEB 18 2009 Report B. Jacket
DH	MH 17 Rev 1/2	2001	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 02 12 2009 14:00 PM Charles W. Porter, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air, Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/08/1924 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year Sex 1**X**IM 2□F **Funeral** Months Days Hours 84 Director 216-16-8360 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No iral", or items 23a or 28a-f sh Examiner must be notified Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9612 Alda Drive 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. þ Specify: White 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Harry T. Campbell Co. 11 Plant Expediter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Charles W. Porter, Sr. Maria D. Kraft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2829 Forest Glen Drive - Baldwin, Maryland Patricia L. Castoro (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/17/2009 Baltimore, Maryland Joseph Ch.Cem. e of Funeral Service/Cicenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the diseas shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final embolism Physician Ulyonary disease or condition resulting in death) /Medical e to (or as a consequence of): Examiner 05 Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 T Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Natural 5 Pending investigation 2☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a

Records, P.O. Box 68760

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Mikityanskaya M.D. 500 Upper Chesaplake

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State of M	/larylan		artment of F		nd Mental		ne No.2009	04671
			Registrar  1. Decedent's Name (First, Middle,	Last)			timodio or			of Death		3. Time of Death
	Physicia		MARGARET ELIZABI	ETH PLUMER					Mont		Day Year 13 2009	2:40A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numbe	er)		4b. City, Town, o	Location of I			4c. County of Deatl	n
	o		GILCHRIST CENTER					WSON	Hrs. la D.t.	-( D: 4)	BALTIMO	
	Funeral Director		5. Social Security Number 213-14-0585	6. Sex 1 □ M 2 1 F   87		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date Min. May	of Birth 1974 4, 197	21 9. Birti	hplace (State or Foreign untry) ryland
-	ъ		Usual Residence of Decedent		40- 01		tion					10d. Inside City Limits
	show	'n	10a. State 10b. County  Maryland Baltim	ore	10c. Cit	y, Town or Lo	camon Baltimore	Count	ζV			1 ☐ Yes 2 <b>X</b> No
	the M	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	untry?
3	3a or	a Di	4303 Plumer Ave	าบe				21	236		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a literated Examinar mast be redified at once.	by Funeral	11. Marital Status  ★☆ Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1  Yes & 1 If Yes, Give Year or Dates	s? No		Was Decedent of H If Yes, specify Cuba 1 □ Yes 🍇 🛣 No	lispanic Originan, Mexican, I	n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Ame Black, White Specify: Wh	
	72 ho natur Jicel	eted	15. Decedent's	Education grade completed)		16a. Dece	Decedent's Usual Occupation     (Give kind of work done during most of working life. DO NOT use retired)				. Kind of Business/I	ndustry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4o 2 vrs	r 5+)						A. Bauer	Co.
ם י	other vent, I	Be Co	17. Father's Name (First, Middle, L.	ast)	-				s Name (First, M			
y a	ould by Menta narked natic e	To	Henry John Pluml						Mary Mi			T- 0 - 1-1
2	nd 2 sh alth and 27 is π r traum		19a. Informant's Name/Relationshi Mildred A. Plume		)						ity or Town, State, 2 ,Md.212	
ָט כ	es 1 ar of Hee fitem r othe		20a. Method of Disposition  X Burial 2 □ Cremation	Pamousi from Sta	20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c	. Location - City or	Town, State
Í '	. Page tment tant: I		4 ☐ Donation 5 ☐ Other (Sp	ecify)	St.		h Ch.Cem		-17-2009		llerton,	Maryland
ח	permit Depar Impor any in		21. Signature of Funeral Service L	rsakn		22	2. Name and Addre Lassah 7401 E	ss of Eacility In Fune Belair	eral Hom Rd. Bal	e timor	e, Md. 2]	L236
			23a. Part 1. Enter the disease, or o shock, or heart failure. List o			h. Do not ent	er the mode of dyi	ng, such as ca	ardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LOMI	PUCA as a conseq		OF ADRTI	CVALU	E REPL	ALEN	MENT	WEEKS
	Examiner		O. a. a. Marka Haribara	b Due to (or a	as a conseq	uence or).						
	ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
,	execur n and ial-trar	Exan	that initiated events resulting in death) Last	c Due to (or a	as a conseq	uence of):						
,00,70	cate be executed oblysician and the burial-transit	dical	,	d								
5	ertifice ing ph e as th	Med	IF FEMALE:									
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcon 1  Live birth 4  Pregnan 9  Unknown	n 2□Feta t at time of d	l death 3	Ectopic pregnand Other (specify)	ey		_	23d. Date of del Month	ivery Day Year
,	w requires that the de been signed by the should be detached	by Pi	Part II. Other significant condition		but not res	ulting in the u	nderlying cause giv	en in Part I.	23e	. Did tobac		the cause of death?
5	equire	ted t	ATRIAL FIBR	ILLATION						1 🗌 Yes	2 No 3 □ Pr	obabły 4 🗆 Unknown
בַּ	has be	Completed							24a	. Was an autopsy performed	24b. Were au prior to death?	topsy findings available completion of cause of
ם ו	n: The ficate r, pag									Yes 2	No 1 ☐ Yes	2□No
<u> </u>	siciar s certifi irecto	) Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ⚠ No	Hospital:	ationt 2 🗆	ER/Outpatie	nt 3 🗆 DOA Oth	or	of Death (Check		e 6 🔀 Other (Spec	sify HOSDICE
5 4	ding Physician: The h. h. After this certificate h. funeral director, page	n: To	27. Manner of Death	28a. Date of I		28b. Time o		7 🗀 14010			njury occurred	ony) Hospiec
5	endin sath. or: Aff he fur	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	ation			M 1 □	Yes 2□N				
28d. Describe how injury    Second   Describe   Describ								t and Number or Ru tate)	ıral Route Number,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certified completely filled in by the funeral director, p	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the basis and manner	s of examina	owledge, deat ation and/or ir	h occurred at the to exestigation, in my	me, date and opinion, death	place, and due n occurred at the	to the caus time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the within comp	Me	29b. Signature and title of certifier	2000	$\sim$		29c. Licens	se number 54345			Date signed (Month	
1			30. Name and address of person w		of death (Item	n 23a) (Type,	Print) ARLES ST	· S1117	£ 7.09		TIMORE, M	11 21204
2	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ature /	1	· Dunc		()110	111101001 11	
	Registr		31. Date filed (Month, Day, Year) FEB 18 200	9 Separa	f.	gark			,,			

	State of Maryland /	Department of Health a	nd Mental Hygier	ne Reg. No. 2005	01.67
Dhysisian/	Registrar  1. Decedent's Name (First, Middle,Last)	Certificate of Death		e of Death	3. Time of Death
Physician/ Medical Examiner		Papadakis	Mon Feb or Location of Death	ruary 14, 2009	0142 hrs
	Lodge Farm Road and North Point Road	Edgemere	3 133	Baltimore Cour	-
Funeral Director	5. Social Security Number 6. Sex 7. Age 1219–38–4270 1X M 2 F	67 Yrs. Isst birthday) If Under 1 Ye Months Da	ar If Under 24Hrs. 8. Da ys Hours Min. Au	gust 10,194 Foreign	ntry)Maryland
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
* .	Md. Baltimore	Edgemen Tof. Zip Code	e	10g. Citizen of What Coun	1 Yes 2 X No
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	9006 Hinton Ave.	2	1219	USA	,.
rr death with or items 23 i must be no Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	Ever in U.S. 13. Was Decedent of H If Yes, specify Cub	lispanic Origin? ( Specify Y an, Mexican, Puerto Rican,	es or No- etc.) 14. Race - Americ White, etc.	an Indian, Black,
s after de raile, or nainer me by Fu	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2X		Specify: Whi	
5-0036 ed within 72 hour bygiene. other than "nate the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5	i+) during most of working li	e. DO NOT use retired)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than marked other than for event, the Medica FO Be Comple	12 years 17. Father's Name (First, Middle, Last)	Brew Maste		National 1 Middle, Maiden Surname)	Brewery
121. I be fill sarked arked vent, Be	Nicholas Papadakis	The Million Address (O	Irene Mo	nouydas oute Number, City or Town, State,	Zin Code)
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print ) Gregory Papadakis Sor			re, Maryland 21	
e, N Land 2 Health item 2	20a. Method of Disposition	20b. Place of Disposition (Name of		20c. Location - City or	
Pages nent of nent: If	1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	Holly Hill Memor	ial 19, 20	09   Middle Riv	
Baltimore, ME permit. Pages I and 2.8 Department of Health a Important: If liem 27 injury or other tranm	21 Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused failure. List only one seuse on each line.	22. Name and Addre Connelly 7110 Soll	ss of Facility Funeral Home ers Point Ro	Of Dundalk, P.	A. 21222
Physician	23a. Part I. Enter the disease, or complications that caused failure. List only one seuse on each line.	the death. Do not enter the mode of dyir	g, such as cardiac or respir	atory arrest, shock, or heart	Approximate Interval Between Onset and
/weuical `xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Due to (or as a conse	injuries			Death
- Lo	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):			
nsit Examine	cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last  Due to (or as a conse	equence of):			_
	ď	a,27,28a-f, perME,	g889 3/3/09	ТТ	
	IF FEMALE: 23c. If yes, outcome		G	23d. Date of delivery	
Box 68760, e death certificate be executive attending physician and ed for use as the burial - training physician to by siciania - training physiciania - training physiciania - training physiciania - training physiciani	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at	2 Fetal death time of death 5 Other (Specify)	Ectopic pregnancy	Month D	ay Year
). Box 6i the death cert by the attendii tched for use a	1 Yes 2 No 9 Unknown 9 Unknown		12	2a. Did tahansa uga sastributa ta t	he sound of death?
P. G		n but not resulting in the underlying caus	e given in Part I.	3e. Did tobacco use contribute to t  1  Yes 2 ✓ No 3 Prob	
Records, The law requires ficate has been sig			24		opsy findings available ompletion of cause of
tal Rec		- 00 FI		✓ Yes 2 No 1 ✓ Ye	s 2 No
Vital Rec hysician: The this certificate I director, page	Innatia		ce of Death (Check only on Other: Nursing Hom		Scene
n of \ding Phy After th funeral c	27. Manner of Death 28a. Date of Inju (Month, Day,Y		jury at Work? 28d. I ped	escribe how injury occurred su lestrian struck	bject was a by an auto
risior r Attend ter death, irector: n by the ficatic	2 X Accident Investigation 2/14/20	009 1:37 am jury - At home, farm, street, factory, offic	ros	er falling down	
Division o  Unopital or Attending 24 hours after death. Funeral Director: After tely filled in by the funeral all Certification:	4 Homicide Could not be determined (Specify)		ocation Street and Number of Ru r Town, State) Lodge Far th Point Rd. Ed		
Division  To the Hospital or Attent within 24 hours after death To the Funeral Directors completely filled in by the Medical Certification	29a. Certifier 1 Certifying Physician: To the best of my one)  2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death occurred at the time, mination and/or investigation, in my opin	date and place, and due to on, death occurred at the ti	the cause(s) and manner as state me, date and place, and due to the	d. e cause(s)
A P S S S S S S S S S S S S S S S S S S	29b. Signature and title of certifier		nse number	29d. Date signed (Mor	_
	30. Name and address of person who completed cause of d		C.M.E.	February 14, 200	
P	Ling Li, MD Assistant Medical Examine		e, MD 21201		
State Registrar	1 EED (1900) //1	r's Signature			

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng? 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) homass 4c. County of Death Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death clurass If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours 100 M 2□ F 85 08/11/1923 Rhode Ísland 035-14-5631 Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Columbia Howard 10f, Zip Code 10g, Citizen of What Country? 10e. Street end Number 5400 Vantage Point Road, Apt. 210 U.S.A. 21044 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Science & Technology Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Rogers, Sr. Henorah Flaherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 4510 Mustering Drum, Ellicott City, Maryland 21042 Robert E. Grove Son in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/14/09 Atlantic Crematory, Inc. Glen Burnie, Maryland 21. Signature Funeral Se ce License 22. Name and Address of Facility Witzke Funeral Home. Inc. (11283 5555 Twin Knolls Rd., Columbia, Maryland 21045 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dise Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No D 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 L Yes 2 100 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient

**Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Department of H Important; if Ite any Injury or ot

**Physician** 

/Medical

Examiner

10a. State

**Funeral Director** 

Completed by

Be

**Funeral** 

Director

Peges 1 and 2 should be filed within 72 hours after death with the Meryland

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

if Health and Mental Hygiene. Item 27 Is marked other than "naturel", or items 23a or 28a-f show other traumetto event, the Medical Examiner must be notified at

by Physician/Medical Examiner buriel-tran physician s the buriel ettending p Completed Be ို within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral Medical Certification:

Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I

25.	was case examiner?	reterre	d to medical
	1 🗌 Yes		0
27.	Manner of	Death	
	1 ENatura	1	5 Pending

Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 No

28d. Describe how injury occurred

29a. Certifier

2 Accident

3 Suicide

4 Homicide

the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month. Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 10805

KORIVE 31. Date filed (Month, Day, Year) 22. Registrer's Signature

State Registrar

**DHMH 16 Rev 6/95** 

To the

this

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amennd Items State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 - For A State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician February 2009 Terrie Lee Reynolds /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner VICOMICO Keninswa Kegional Medical Centes 9. Birthplace (State or Foreign Country) Delaware If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Aug 19, . Age (In yrs. last birthday) Social Security Number <sup>Year)</sup> 1958 **Funeral** Days Months Hours 1 □ M 2 🛱 F 50 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2√ No Director Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21804 31105 Stevens Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: white Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) foster care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Bernard Brittingham ALma Jean Bruce ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Reynolds/spouse 31105 Stevens Lane Salisbury, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Sicensee Director mi 92 Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** Due to (or a consequence of): Cance /Medical Examiner Smoking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e conse mence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant et time of death 5 Other (specify) i signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown tension Completed icate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform penormeg? 1 ☐ Yes 2 🖾 No 1 ☐ Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Nation 2 ER/Outpatien 3 DOA ဥ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) Feb. 5, 206 29c. License number 29b. Signature and title of certifier MD. D39204 100 E. Carroll St, Salisbury, MO 21801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRMC Bennett 82. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed "Mohitif, Day, Year)" "

182009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	•	epartment of F Certificate of		, ,	g. No. 2 () () 9	04675		
	Physicia		1. Decedent's Name (First, Middle, Last)	Dora	P. So	choeberlein		2. Date of Death Month Feb.	Day Year 14, 2009	3. Time of Death 7:45 P M		
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1 0 0	4c. County of Deat			
			Manor Care Ruxton			Tows		0.0.4.7.8.4	Baltim	ore Co.		
	Funeral Director		220-14-4780		(In yrs. last birtl	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 7	Year) 1923 Mar	hplace (State or Foreign unity) y Land		
	ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town		D - 1 +			10d. Inside City Limits		
	e Mar	Director	Maryland N/A				Baltimore			1 ∑Yes 2 ☐ No		
	th with th		10e. Street and Number 6817 Gough Stre	et		10f. Zip Code	21224		g. Citizen of What Co United Sta			
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
3036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Marchael Eventher marked any once.	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 □ Yes 2 🕅 No If Yes, Give Year or Dates:		1 □ Yes 24 No			Specify:	White		
15-	"natt	lete	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work d)	ing 1	6b. Kind of Business/	Industry		
212	l withii jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		Bookkeeper	-7		Accoun	ting		
פ	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Surname)			
ylar	Menta	2	Raymond Watson				Dora Un	nger				
Jar	12 sho	9	19a. Informant's Name/Relationship (Ty		- 7.1	Mailing Address (Street 2205 Elliota				Zip Code) 21161		
Ġ,	1 and Healt tem 2		Mrs. Denise Nader	(Daugnte		Disposition (Name of y, crematory or other pla			0c. Location - City or			
Baltimore, Maryland 21215-0036	t. Pages tment of tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	<i></i>	Hillto	op Service	Corp. 2/1		Towson, M			
Ba	permil Depar Impor any In		21. Signature of Funday Service Licen	PUL	-	Duda-Ruck 7922 Wise	Funeral Ave. Du	Home of ndalk, Ma	Dundalk, I aryland 2	nc. 1222		
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do n e.	not enter the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition									
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):									
		Je.	Sequentially list conditions, if any, leading to immediate outdo. Enter Underlying Cause (Disease or injury	Due to (or as a	o (or as a consequence of):							
	ransit and	Examiner	that initiated events	c								
60,	ificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a	a consequence o	of):						
68760,	fficate y phys is the	edical		1								
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours attendeath.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth = 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of del Month	ivery Day Year		
σ <u>.</u>	ned b	y Ph	Part II. Other significant conditions co	ntributing to death bu	it not resulting in	the underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
rds	quires	ed by	Malnutrit	MON			1 ☐ Ye	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐				
900	law re ias be 2 sho	plet	Dementi	9				24a. Was an	nrior to	utopsy findings available completion of cause of		
24a. Was an autopsy performed:  1   Yes   Court   Cour						led? death? No 1 ☐ Yes	2 No					
Ĭ;	ician certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		_ Tot		th (Check only one				
ō	Phys rr this aral dii	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	ry 28b. T	Time of 28c. Inju	4 A Nursing H	ome 5 Resider  28d. Describe hove	nce 6 □ Other (Spe w injury occurred	cify)		
on	nding tth. :: Afte e fune	ation	1 Natural 5 ☐ Pending investigation	(Month, Day	<i>i, Year)</i> Ir		rki? ∐Yes 2 ∐No					
Division of Vital Records,	or Attend after death Director: /	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	e Hospital 124 hours a e Funeral letely filled	Medical Co	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	iner: On the hasis of	examination an	e, death occurred at the d/or investigation, in my	opinion, death occu-	rred at the time, da	ate and place, and due	e to the cause(s)		
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mont	h, Day, Year)		
	1		Kirklatko	Atten	ding	Do	05928	33 F	ebruary.	16,2009		
	5		30. Name and a die is of perior \ ho c	mpleted cause of de	eath (Item 23a) (	(Type, Print)	1 -	# 211 -	Tarre	MAD DIDOL		
	Sta	to	31. Date filed (Month, Day, Year)	82. Registra	5 415 Ir's Signature	Bellong	Lane:	# 216,	10mzon	n, Day, Year)  16, 2009  MD 21204		
	Registr		rro18	2000	MARKET 1	D. Barker						

Dir

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending about the control of the Division of Vital Records, P.O. Box 68760,

		Please Type or P State of 1 - For State Registrar		d / Depa		lealth and M	ental Hygie	ne 200	9 04676		
ysicia	1. Decedent's Name (First, Middle, Last)		A				2. Date of Death Month	Day Year	3. Time of Death		
Medic camin	al	4a. Facility Name (If not institution, give street and number				r Location of Death	February	14,2009 4c. County of Deat	1:45 P <sup>M</sup>		
		3838 Roland Ave. Apt.				ltimore City		N/A	(0)		
neral ector		5. Social Security Number  219-42-7426  0	. Age (In yrs. I	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 1,1	9. Biri 945 Ma	thplace (State or Foreign ountry) aryland		
Ħ		10a. State 10b. County		10d. Inside City Limits							
any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Maryland N/A			Bal	-	1X Yes 2 □ No				
pend		10e. Street and Number  3838 Roland Ave.	Apt. 70	3	10f. Zip Code		10g. Citizen of What Country? United States				
L'minst	nera	11 Marital Status 12, Was Deced	ent Ever in U.S					r No- 14. Race - American Indian,			
mine	by Fu	Armed Force  1 Never Married 2 Married 1 Yes 1  If Yes, Give	No P				iican, etc.)		Black, White, etc.  Specify:		
al Ex	ed b	3 ☐ Widowed 4 ☑ Divorced Year or Dat	es:	16a. Decedent's Usual Occupation				. Kind of Business/	White		
Medic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)	lor 5+)	(Give kind of work done during most of working life. DO NOT use retired)					·		
t, the		12 Years		Cust	omer Ser	vice 18. Mother's Name	(Eiret Middle Mol	Comcast			
c ever	Be c	17. Father's Name (First, Middle, Last)  Charles Clarke					Balzano	den Sumame)			
иmati	ပ	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Rura	Route Number, C	ity or Town, State, a	Zip Code)		
er tra		Mrs. Lori Ann Turner (Dau			Jaydee		dalk, Mar	<u></u>	1222		
or off		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State									
injury F.		4 ☑ Donation 5 ☐ Other (Specify)  21. Signature of Juneral Service License	Hi			Corp. 2/19		Towson, l			
any		21. Signature of Junera Septice Ligensate Duda-Ruck Funeral Home of Dundalk, Inc.  7922 Wise Ave. Dundalk, Maryland 21222									
		23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between									
cian		Immediate Cause (Final disease or condition resulting in death)  a. AHOUDS CLOSE RUIT DIRACE Onset and Death 13 Lyding.									
dical iner		Due to (o	r às a consequ	ience of):							
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequ	ience of):							
transit	Examiner	triat illitiated events									
burial											
as the	edic	d									
r use s	an/M	IF FEMALE:  23b. Was decedent pregnant  1 □ Live bi	cy		23d. Date of de	·					
should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month	Day Year						
detac		Part II. Other significant conditions contributing to dea	23e. Did tobac	acco use contribute to the cause of death?							
anld be	ed by	Dialogo Mypa, Ir pilloudo 10 Yes							2 No 3 Probably 4 Unknown		
N	Completed	24a. Was an autopsy find to complete									
r, page		performed? death? 1 \text{Yes 2 \text{UNO}} 1 \text{Yes 2 \text{NO}}									
lirecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In	patient 2 🗆	EB/Outnatie	nt 3 DOA Oth	26. Place of Death ner: 4 ☐ Nursing Hon		e 6 □ Other (Spe	city)		
neral c	n: T	27. Manper of Death 28a. Date of		28b. Time o		ry at 2	8d. Describe how		(chy)		
the fu	catic	2 Accident investigation			M 1 □	]Yes 2□No					
d in by	Certification: To	dotarminad   286, Place C	of Injury - At ho g, etc. <i>(Specif</i>	me, farm, str y)	reet, factory, office		8f. Location (Street City or Town, S	t and Number or R tate)	urai Route Number,		
completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
фшоо	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
Sta	te		gistrar's Signa	l// No ture	40- 5	Inel Sti	W 212)	BUTTIN	TUND -4)		
egistr	ar	FEB 1 8 2009	136th	p. 19	Carles						

State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 6:40 a м **FEBRUARY** HERBERT J. SCHAFER sr17 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2601 BALDWIN MILL ROAD BALDWIN HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 81 Yrs. 219-36-0140 12-18-1927 Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD BALDWIN 1 ☐ Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2601 BALDWIN MILL ROAD 21013 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2X Married Maryland 21215-0036 1 □Yes 21√2 No Specify. Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED ENTREPRENEUR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be JOHN SCHAFER, SR. MAGDALENA HELEN (KLEIN) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY L. SCHAFER/WIFE 2601 BALDWIN MILL ROAD BALDWIN, MD 21013 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JOHN'S CHURCH 2-21-09 HYDES, MARYLAND 21. Signature of Funeral Service Picensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 ROSEDALE, CHESACO AVE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the a I I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 □ Yes 2 11 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DE014221 3

Registrar

State

31. Date filed (Month, Day,

2

12. Bloo BRLT WW 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

win

32. Registrar's Signature

		Plea - For	se Type or Prin State of M				. Ensure A Health and I	-		_	01 670	
	•	1 - State Registrar			Cei	rtificate of	Death		Reg. No	2009	04618	
		1. Decedent's Name (First, Middl	le, Last)					2. Date of De		Voor	3. Time of Death	
Physicia		BERNADE	TTE S	PRV	ELL	_		Month FEB	16		2:27 PM	
/Medic Examin		4a. Facility Name (If not institution					or Location of Death			. County of Death		
		HARBOR +	HOSPITAL	_		BAL	TIMOL	2E		N/A		
Funeral		5. Social Security Number		je (In yrs. lasi	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year	9. Birth	place (State or Foreign	
Director		220-68-3784	1□M 2☐XF	50	Yrs.	Worteris Days	Tiours Iviii.	JUNE ]			RYLAND"	
p. ,		Usual Residence of Decedent		10c. City, T	Farra and a	anti				1.	10d. Inside City Limits	
aryta shov	_	10a. State 10b. County		Tuc. City, 1	IOWN OF LO	Cation					1XXX/es 2 □ No	
Ba-f	Director	MARYLAND N/A	A		BALT	IMORE			40- 0	711111111111111111111111111111111111111		
/ith th	吉	10e. Street and Number				10f. Zip Code			iug. C	itizen of What Cou	ntry?	
ours after death with the Maryland ral" or Items 23a or 28a-f show Examiner must be notified at	Funeral	2547 LAURETTA		E 12 11 0	140		223	:6.VaA		J.S.A. 14. Race - Ameri	!!:	
er de Item	Š	11. Marital Status	12. Was Decedent Armed Forces? ried 1 □Yes 2 X	•	13.	If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	o Rican, etc.)	0-	Black, White,		
s aft	by	1 XX ever Married 2 Mar 3 Widowed 4 Divorced	If Yes Give	<b>₩</b> O		1∐Yes 2 <b>XX</b> No	Specify:			Specify: BLA	CK	
72 hours 'natural'', digal Exa			nt's Education		16a. Dece	dent's Usual Occu	pation		16b. F	Kind of Business/In		
in 72 n "na n edia	Bet	(Specify only highe	est grade completed)	F.,\	(Give life.	kind of work done DO NOT use retire	during most of wor ed)	king				
filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or	D+)	CC	OK			I	FOOD SERV	'ICE	
othe rent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle	e, Maidei	n Surname)		
ald be Aental rked o	일	AMOS SPRUELL					ISABELI	MAYFIE	ELD			
should and Mer s marke umatic		19a. Informant's Name/Relations	ship (Type. Print)		19b. Maili	ng Address (Street	t and Number or Ru	ral Route Numi	ber, City	or Town, State, Zij	Code)	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene I fine I filem 27 is marked other than "reatural", any Injury or other traumatic event, the Medical Exagnese.		Isabell Gray/M	Mother		2547	LAURETT	A AVE P	ALTO. M	ID 2	1223		
ss 1 as of He item		20a. Method of Disposition			e of Disponetery, crea	sition (Name of matory or other pla	ice)	Date	20c. L	ocation - City or To	own, State	
Pages nent of int: If its		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation _ 5 ☐ Other (S			TRO C	REMATORY	02-1	8-09	BAI	TIMORE, M	ARYLAND	
permit. Departn Importa any Inju		21. Signature of Funeral Service	Ticensee	,	22	2. Name and Addre	ess of Facility BROWN CC	MMIINITERS				
88 = 88		1 Detal S		_			RTH AVENU		. ror	VERAL HOM	E F.A.	
Physician /Medical Examiner	ıl Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. AND Due to (or as  b. Due to (or as  c. END	a consequer	nce of):	CEU	LUNG	CA,	~CZ	R	Interval Between Onset and Death	
	dica		d									
ne death certif the attending hed for use as	ysician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3[	□Ectopic pregnan □Other (specify) _	су			23d. Date of deliv Month	ery Day Year	
uires that the signed by	d by Phys											
w requir been s should	Completed	PERIPHERAL VASCULAR DISEASE 24a. Was an autonsy						24b. Were autopsy findings available prior to completion of cause of				
he lav e has ge 2	m d						1)50	auto	opsy formed?	✓ death?		
n: Ti ficate or, pa		DILATED  25. Was case referred to medica	CARDIO	77790	PAT	714	00 84	1 ☐ Yes		o 1⊡Yes	2 No	
sicia certi recto	Be	examiner?  1 Yes 2 No			2/0. 41:-	nt 3 DOA Ott	26. Place of Dea			6 ☐ Other (Speci		
Phy r this	i: To	27. Manner of Death	28a. Date of Inj	ury 2	8b. Time o	III OLIDOA	4 🗆 Ivuising n	28d. Describe			ry)	
ding th.	tior	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, Da	ay, Year)	Injury		rk? ]Yes 2.∐No					
l or Atter after deat Director	Certification:	3 Suicide 6 Could 4 Homicide deterr	not be 28e. Place of In	jury - At hometc. (Specify)	e, farm, st	reet, factory, office		28f. Location City or To	(Street a	und Number or Rur te)	al Route Number,	
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C		ing Physiclan: To the best I Examiner: On the basis and manner s	of examinatio								
To th withir To th	Me	29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)		
		> JKgand	W M			RE	5000	1	FE	B,16	,2009	
0		30. Name and address of person	n who completed cause of	death (Item 2	:3a) (Type,	Print)						
2		JEET GAND	>HI , 308	01 50	UTH	1 HANG	OVER S	TREET	BA	LTIMORE	MD-212	
Sta	te	31. Date filed (Month, Day, Year,	32. Regist	rar's Signatur	re	. 20					/	
Registr	ar	FFR 1 8 201	ng Messel	A. 16	Back							

The law requires that the death certificate be executed attending physician for use

Division or Vital Records, P.O. Box 68760, Hospital or Attending

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Day Year 0506 February 15 2009 WILBUR /Medical SMITH 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospital Bultimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 XM 2 ☐ F 68 Director 06-26-1940 243-64-9569 NC Usual Residence of De 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 ¥Yes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3444 VIRGINIA AVENUE 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: If item 27 is marked other tha any Injury or other traumatic conce. LIBERTY ROOFER ROOFING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EVELENA** SMITH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YOLANDA PROCTOR/DAUGHTER 1527 LOCHWOOD RD., BALTO., MD 21218 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-09 BALTIMORE, MD **METRO** 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility JAMES A.MORTON & SONS F.H, INC mes 4 enten 1701 LAURENS ST., BALTO., MD 21217 23a. Part1 Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sept/c
Due to (or as a consequence of): Days Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rpertensio 24a. Was an was autopsy performed 2 No Herner lipidemia funeral director, 25. Was case referred to medic examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death • Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 9

Physician /Medical Examiner

**Funeral** 

For

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the "widgal Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar		Cei	rtificate of	Death		Re	g. No. 7	109	0		
	1. Decedent's Name (First, Middle, Last)			2. Date of Deat	3. Time of Death							
1	Inez Spet			1	February	12 2	Year 2009	10.34AM				
r	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location o			4c. Count	ty of Death	1.0		
	5517 Green Dory Lane	Cc		Howard								
	5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year			8. Date of Birth (Month, Day,	Va a v)	9. Birthp	lace (State or Foreign		
	213-74-2345	M 2 <b>X</b> □ F 103	Yrs.	Months Days Hours Min.			11–16–1907 South D					
	Usual Residence of Decedent											
	10a. State 10b. County 10c. City, Town or Location 10d. Inside City											
2	MD Howard Columbia									1 ☐ Yes 2 ☐ No		
Ē	10e. Street and Number			10f. Zip Code			10	0g. Citizen of	What Coun	try?		
_ 	5517 Green Dory Lane			21044								
<u>je</u>		2. Was Decedent Ever	in U.S. 13. V	Was Decedent of f Yes, specify Cut	Hispanic Orig	gin? (Spe	cify Yes or No-	U.S.A. No- 14. Race - American Indian,				
2	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 🛣 No				i, Puerto I	Hican, etc.)	Bla	ack, White, e	etc.		
5	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	1⊡Yes 27∏ No	Specify:			Speci	fy:White	i		
ec	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occu	pation		- 1	16b. Kind of E	3usiness/Inc	dustry		
completed by Funeral Director	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of work done DO NOT use retire	during most d)	ot workir	ng					
E	12	Conege (1-40f 5+)	Hon	mennaker				Own Home	<u> </u>			
e C	17. Father's Name (First, Middle, Last)	•			18. Mothe	r's Name	(First, Middle, N	laiden Surna	me)			
0 00	Stephen Pearson				Agnes	s Flag	stad					
=	19a. Informant's Name/Relationship (Typ	a Print)	10h Mailin	ng Address (Stree				City or Town	Ctota 7	Cadal		
	Paul C. Spehr/son	o. r timy							i, Siale, ZIP	Code)		
1				ley View 7				17320	Cit T	State		
	20a. Method of Disposition  1 ☐ Burial 2 ▼ Cremation 3 ☐ Be	emoval from State	<ol> <li>Place of Disposition cemetery, cren</li> </ol>	sition (Name of natory or other pla	·					Location - City or Town, State		
	4 ☐ Donation 5 ☐ Other (Specify)	To burial 2 Ligit Cremation 3 Chemoval from State										
	21. Signature of Funeral Service License	e		. Name and Addr								
	( and In	Mere	1 F	litzke Fune	ral Hon	nes, I	nc. Olumbia 1	VID 210/-	5			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
jj	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final  Onset and Death											
	disease or condition resulting in death)	disease or condition resulting in death)  a.										
		Due to ( r as a cor	nsequence ):	MACAR	An							
_	Sequentially list conditions, b.	Dun to (or no ball	10000	MCRO	DVI							
	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying  Due to (or as insequence of):											
Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Duals /										
îi =	Training in death) Lust	Due to (or as a cor	isequence of):									
Ca	d.											
n/Medical	IE EEMALE:											
	23b. was decedent pregnant	Bc. If yes, outcome of pr	egnancy	Ectopic pregnan	2)/			23d. Da	ate of delive	of delivery		
CIE	in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	of death 5	Dectoric pregnan Other (specify)	_y			M	lonth	Day Year		
3	9 Unknown	9 ☐ Unknown										
Completed by Physicia	Part I. Other significant conditions cont	tributing to death but no	t resulting in the ur	nderlying cause gi	ven in Part I.		23e. Did tob	acco use cor	tribute to th	e cause of death?		
2	I KUUWWWW.	1 AW	WIM	M			1 □ Ye	s 2 No	3 ☐ Prob	ably 4 Inknown		
ere				1			-					
1		J				<del></del>	24a. Was ar autops	/	prior to cor	psy findings available npletion of cause of		
5							perform	ed?	death? 1 □ Yes	2 □ No		
25. Was case referred to medical examiner?												
								nce 6 □Ot	her (Specifi	()		
	27. Manner of Death	28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	28c. Inju	ry at		8d. Describe ho			<u>,                                      </u>		
2110	1 Natural 5 Pending 2 Accident investigation	(World), Day, 168	ar, ingury		rk? ]Yes 2.∐1	No						
To Spiral 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)    27. Manner of Death 1   Natural 2   Accident investigation 3   Suicide 4   Homicide   Specify    28a. Date of Injury 2   28b. Time of Injury 4   Work? 1   Yes 2   No    28b. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Num City or Town, State)    29a. Certifier (Check only one)   Other (Specify)    29a. Certifier (Check only one)   Other (Specify)    29b. Signsture and title of certifier   29c. License number    29d. Date signed (Mooth, Day, Yaz)    29d. Date s									ber or Rura	l Route Number.		
٥	29a. Certifier 12 Certifying Physi	ician: To the best of my	knowledge death	n occurred at the	ime date on	nd place of	and due to the e	nice/e) and -	nannor oo	tated		
Ca	(Check only one)	er: On the basis of exa	mination and/or in	vestigation, in my	opinion, dea	th occurre	ed at the time, da	ate and place	, and due to	the cause(s)		
Ne C		and manner stated.		000 11	no Dumb			Jd D-+- '	ad /8 4=	Dev. Vani		
-	29b. Signature and title of certifier	OLLLA	LAMA	29c. Licen	se number	200	/  _	d. Date signe				
	I MAD WOOD	CHUVE	ZVVVV	DO	05/6	158	1	POVUO	MI	3 2009		

DHMH 17 Rev 1/2001

State

Registrar

5450 KNOW NOWN Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- BOULS BUT, WD 5450 (WOLL)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 1 8 2009

**Physician** INGELO February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BA / timo/E
If Under 1 Year | If Under 24 Hrs. MEMORIAL HOSPITAI 8. Date of Birth Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 313-70-143 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiens "Income age used the properties of the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Ever fract rust be notified at once. BAltimorE **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2/2/8 Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIAC HT Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAlta Works 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HUBB ATD BAI BAR A 19a. Informant's Name/Relationship (Type. Print) MOTAFT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2643 TENNELLYST BAlto MD 21218 AP+5 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 2-21-2009 BAlto ZION CEM MOUNT 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ph. 11 1P A WEATH FREEP FS PA 21. Signature of Euneral Service Licensee

22. Name and Address of Facility Fig. 11 of A WET

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OLIVER SI BAH MD -1213 Immediate Cause (Final Sepsis **S** Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No

1. Decedent's Name (First, Middle, Last)

the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Physician/Medical Examiner mmuno deficiency Syndrome 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 A 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

3:20

9. Birthplace (State or Foreign Country) 7.

10d. Inside City Limits

Approximate Interval Between Onset and Death

a

1∕□Yes 2□No

2009

State Registrar 31. Date filed (Month.

eral Director: After thi filled in by the funeral

within 24 hours a To the Funeral D

nion

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For	Plea	se Type or Amend#5 State o	Print per of Mai	L <b>in B</b> Fhg8 ryland						II Copie: Mental H	s Are	e <b>Legib</b> ne	le.	
Physicia	ın	State Registrar  1. Decedent's Name CHΔDLES		e, Last) SCHWARTZ			Cer	rtifica	te of L	Deati	h	2. Date of D Month February	D	20	09 Year	3. Time of Death 9:35A M
/Medic Examin		4a. Facility Name (III Blakehurst			umber)				Town, or	Locatio	n of Death			c. County o	f Death	
Funeral Director		5. Social Security N 215–14–8238	8138	6. Sex M 2□ F	7. Age 96		st birthday) Yrs.	If Unde Months		If Und Hours	er 24 Hrs. Min.	8. Date of B (Month, L Dec 30,	irth Pay Yea 1912	r) N	9. Birth Cou <b>/ary</b> I	place (State or Foreign ntry) and
Maryland f show	tor	Usual Residence of 10a. State Maryland	10b. County  Baltim	ova		10c. City,	Town or Loc	cation								10d. Inside City Limits 1 ☐ Yes 3 ☐ No
h with the P 23a or 28a- st be notif	Funeral Director	10e. Street and Nur 1055 West	mber			TOW	SOII	· ·	p Code 21204				10g. 0	USA	hat Cou	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantina must be notified at once.	2	11. Marital Status 1 □ Never Marri 3 <b>XX</b> Widowed		If Yes, G	orces? 2 ∏ No iiv <b>e</b>		'	Was Dece fYes, spe I∐Yes	city Cuba	ispanic ( an, Mexic <i>Sp</i> ec <i>i</i>	an, Puerto	pecify Yes or No Rican, etc.)	0-		, White,	can Indian, etc. hite
within 72 ho ene. than "natur he Medical	Completed	(Spec	ify only highe	t's Education st grade completed College	) (1- <b>4</b> or 5+	)	_	dent's Usu kind of wo DO NOT u	ork done d ise retired	ation during m d)	ost of work	king		Kind of Bus		dustry
uld be filed Mental Hygi Irked other Itic event, I	To Be Co	17. Father's Name (		Last)				pprais				e (First, Middl Shreck				
and 2 sho Health and I Im 27 is ma ther traums		Jacqueline	C Parks	hip (Type. Print)	POA		1055 W	est Jo	oppa R	bad 7	Towson	ral Route Num Marylar	nd 21			
nit. Pages artment of hortant: If ite		20a. Method of Disp 1 Denation 21 Signature of Fu	☐ Cremation 5 ☐ Other (S	1.1	State		nece of Disposimetery, crem	ley Ma	ausole	um f	eb 19	, 2009	Tim	onium M	aryl	
permi Depa Impo any Ir once		23a, Part 1. Enter th	he disease, or	Aln Jest complications that	caused t	the death.			6500	York	Road E	Baltimore	e, Ma			
Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):											Onset and Death			
be executed iician and burial-transit	al Examiner	Due to (or as a consequence of):  cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):														
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown    Description   D											Date of delivery Month Day Year				
luires that to n signed by lid be detac	þ	Part II. Other signif	ficant conditi	ons contributing to	death but	t not resul	ting in the ur	nderlying	cause giv	en in Pa	rt I.			1.		the cause of death?
: The law rec cate has bee , page 2 shou	Completed												opsy formed?	pr de	for to co eath?	opsy findings available ompletion of cause of
s certification	o Be	25. Was case refer examiner? 1 ☐ Yes 2 ☑		Hoenital:	Innation	at 2 🗆 E	ER/Outpatier	y 2□□	OA Oth	\		th <i>(Check only</i> ome 5 ☐ Re		€ □ Otho	r (Cana	75.1
ending Phy ath. ir: After this	ation: To	27. Manner of Deat Natural 2 Accident	h 5 🗆 Pendir investi	28a. Date (Mo		у :	28b. Time of Injury		28c. injur Worl	v at		28d. Describe				<u> </u>
ital or Atte irs after de ral Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	nined 28e. Plac build			ne, farm, stro )					City or To	òwn, Sta	ate)		al Route Number,
the Hosp nin 24 hou the Fune npletely fil	Medical	one)	<sup>e</sup> 2□ Medicai		ne best of basis of inner stat	examinati	vledge, deatl ion and/or in	vestigatio	n, in my c	pinion, o	death occu	e, and due to the rred at the time	e, date a	and place, a	nd due t	to the cause(s)
P with Co	2	29b. Signature and	Kia	~	w	)		29	oc. Licens	S 8	30	3	\$ C	Sate signed	(Month,	17 2009 17 2009
2		30. Name and/addr	L M	CHMI	Begistre	r's Signat	23a) (Type,	Print)	N. (	in	ries	ST	100	15UN	W,	21204
Sta Registr			1 8 200	19 /	registial	A J	Joseph .	P								

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

10:40

FEBRUARY

TRIPLET

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009<sup>Year</sup> Day Feb. Vivian Tohanczyn 14, 4:35 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring er 1 Year | If Under 24 Hrs. Montgomery If Under 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 217 F Days Hours Min Yrs. 87 Sept.10,1921 510-18-2133 Kansas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Montgomery Aspen Hill 1 □Yes 2 Xio 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1919 Hickory Hill Lane 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X es 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 📉 No White Specify: WWII 3 Widowed W Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Vice President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Golda Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1919 Hickory Hill Lane, Aspen Hill, MD 20906

20c. Location - City or Town, State

**Physician** /Medical Examiner

ling physician and 9 as the burial-trans

attending p for use as

been signed by the should be detached

certificate

s after death.
I Director: After this of in by the funeral d

24 hours a

within 2 To the

51

Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic event once.

For State Registrar

10a. State

MD

Henry Nelson

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print) Lesley Riehm, Daughter

1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Barbara Supanich, MD

31. Date filed (Month, Day, Year)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

s 23a or 28a-f show

ò

Directo

Funeral

δ

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	1 □ Burial 2 □ Cremation 3 <b>k</b> 4 □ Donation 5 □ Other (Specify		Medcure, I	nc.	02/17/2009	Por	rtland,	Oregon
	21. Signature of Funeral Service/Licen	ISee M0111	3 22. Na	me and Address of F	acility Harma	an Fune	eral Ser	vice, PA
	Julio LATU		722	1 Grayburi	n Drive, Gl	len Bui	rnie, MD	21061
	23a. Part 1. Enter the/disease, or comp shock, or hear failure. List only Immediate Cause (Final disease or condition	one cause on each line.	ne death. Do not enter the		·		356	Approximate Interval Between Onset and Death VYS
	resulting in death)	u	consequence of):	05020027	parmorary	<u> </u>	<u> </u>	710
		Congesti	ve Heart Fa	ilure				days
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
	Cause (Disease or injury	End Stag	re Dementia					yrs
Ž	resulting in death) Last		consequence of):					
<u>8</u>		d.						
Be								
ysician/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □Unknown	23c. If yes, outcome of 1 Live birth 2 Pregnant at ti 9 Unknown	☐ Fetal death 3 ☐ Ect	opic pregnancy er (specify)		_	23d. Date of de Month	elivery Day Year
ر ا	Part II. Other significant conditions of	ontributing to death but	not resulting in the underly	ying cause given in F	Part I. 23e	. Did tobacco	use contribute to	o the cause of death?
5						1 X Yes	2 □ No 3 □ P	robably 4 ☐ Unkno
Complet						. Was an autopsy performed? Yes 2 24	prior to death?	utopsy findings availal completion of cause of
9	25. Was case referred to medical examiner?				Place of Death (Check			
2		Hospital: 1 Inpatient	2 ER/Outpatient 3	DOA Other: 4[	☐ Nursing Home 5 ☐	] Residence	6 ☐Other (Spe	ecify)
ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, )	∕ear) 28b. Time of Injury N	28c. Injury at Work?	28d. Des	cribe how in)	ury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, street, f (Specify)	actory, office	28f. Loca City	ition (Street a or Town, Sta	and Number or R ite)	tural Route Number,
edical			my knowledge, death occ xamination and/or investi d.					
Ž	29b. Signature and title of certifier	0		29c. License num	ber	29d. D	ate signed (Mon	th, Day, Year)
	Barbara S	upanich	RSW MD	D0065	485	0	2/14/	7009

20b. Place of Disposition (Name of cemetery, crematory or other place,

DHMH 17 Rev 1/2001

State Registrar Holy Cross Hospital Center, Silver Spring, Maryland

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 12 , 2000 Tippett Marion Ruth /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gler Arunder ociltimore Washington Medical Cent 8. Date of Birth (Month, Day, Year) Security Number Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 □ M 2XCXF 83 165-22-8426 Director 30,1925 Pennsylvania June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amy Injury or other traumatic event, the Medical Exymitrar must be notified at once. Anne Arundel Severn 1 ☐ Yes 2 ☐ No MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1859 Montreal Rd. 21144-1557 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☐X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u> J Bookkeeper</u> Bank Teller Banking & Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Edward Hughes Ruth Baxendell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Clouse / Daughter 1859 Montreal Rd., Severn, MD 21144-1557 20b. Place of Disposition (Name of cemetery, crematory or other place) Uniformed Services 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/13/09 Bethesda, University 22. Name and Address of Facility Rapp Funeral & Cremation Services Silver Spring, MD 4X Donation 5 ☐ Other (Specify) 21. Signature of Funera m00382 Sussic 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cona **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 robably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No 24a. Was an autopsy performed Yes 2 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Sunpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, has been signed by the attending physician e 2 should be detached for use as the buria within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  $\epsilon$ the

Pages 1 and 2 should be filed within 72 hours after death with the Marylan

INPEET, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

29b. Signature

and title of cer

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, OF

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Amy Jo Tharpe 11:20 A<sup>M</sup> February 12, 2009 /Medical 4c. County of Death 4h City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore <u> Greater Baltimore Medical Center</u> Towson 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2**X** F May 10, 1961 Maryland 213-84-9020 Director Usual Residence of Decedent 10a. State Md 10d. Inside City Limits 10c. City. Town or Location 28a-f show 1 ☐Yes 2X ☐No injury or other traumatic event, the Medical Examiner must be notified Director Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA ö 21128 9615 Haven Farm Road, Unit 6 **23a** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? or items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 XNever Married 2 Married h H K P C H M G Baltimore, Maryland 21245-0036 1 ☐ Yes 2 📉 No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Manany injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) Disabeled Disabeled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Joseph C. Tharpe Be Doris Gerhold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9615 Haven Farm Rd. Perry Hall, Md 21128 Patricia Derus- Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/16/2009 Woodlawn, Md Woodlawn Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home Inc. 21. Signature of Funeral Service Licensee 110/490 1630 Edmondson Ave. Catonsville, Md 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 5 WEEKS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to limited atte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending properties for use as 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det **₽** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DYSPHAGIA Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2√No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu completely To the l within 2-

> State Registrar

30 Name and address of person who completed cau 31. Date filed (Month, Day, Year) FEB 1 8 2009

29b. Signature and title of certific

se of death (Item 3a) (Type, Print) G2055 PO HDS \$159 2. Registrar's Signature

29d. Date signed (Month, Day, Year)

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or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	l Wallace			//aryland / Depart	ment of H	ealth and	l Menta	Hygie			200	9 0	468
			1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Certii	icate of Di	eatti		2. 0	Reg.		3.	Time of Deat	
⇔ edic	Phycicia al Exami			Lemuel	Wallac	ce		F	onth Debruary 4,	2009 Y	ear	1450 hrs	
			4a. Facility Name (if not institution, give stre	et and number)	4b. (	City, Town, or t	ocation of D	Death		4c. Count	y of Death		
			4500 Block of North Franklinto			Saltimore f Under 1 Year	If Under 2	24Hrs 8	Date of Birth(	MM/DD/YYY	YYY 9, Birthp	lace (State or	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last	1	Months Days		1.60	7-5-19		Foreign Coun		
	Director		219-98-5290 1X M  Usual Residence of Decedent	2 F 37	Yrs.				7 3 1.				
	any		10a. State 10b. County	10c. City, To	own or Location							0d. Inside City	
	nd show a	7	MD BALTIN	MORE OW	INGS M	ILLS						Yes 2	A ANO
	Maryland 28a-f show any d at once.	Director	10e. Street and Number		10	0f. Zip Code	_				What Countr	y?	
	i, IVID Z 1Z 13-0030 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.		4535 MaryKnoll	Road Was Decedent Ever in U.S.	13 Was D	2111 Decedent of His		n? (Specif		U S A		in Indian, Blac	ik,
	or items?	Funeral	11. Marital Status  1 X Never Married 2 Married	Armed Forces?	If Yes,	specify Cuban	, Mexican, P	Puerto Rica	an, etc.)	W	hite, etc.	_	
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21215_0036	filed within 72 hours after Hygiene. ed other than "natural", t, the Medical Examiner	Completed	12th grade  17. Father's Name (First, Middle, Last)	N/A	DISG		18.Mother's	Name (Fi	rst, Middle, Ma				17
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1		-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Kı	ng Mem	ne and Address			ch Ea			COWITY	
0	<b>Ball</b> permit. Depart Impor		1 Som to Mullin			101 E		th A	Avenue	Bal	to, M	D 212	
7 . J	Physician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each I	tions that caused the death. I	Do not enter the	mode of dying	such as ca	rdiac or re	espiratory arres	t, shock, or	heart	Approximate Between Or	nset and
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,	Box 68760, e death certificate be the attending physic ed for use as the but	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnt Live birth		il death 3	Ectopic	: pregnanc	:y	Mont	te of delivery th D		<b>Ye</b> ar
,	× 68 th certi	i	past 12 months?	Pregnant at time of dea	ath 5 Othe	er (Specify)							5
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	H		30. Name and address of person who con Zabiullah Ali, M.D. Assist	mpleted cause of death (Item ant Medical Examiner		n Street, Ba	altimore, I	MD 212	01				
	_	Stat		32. Registrar's Signati		and a							

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Registrar

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		Registrar  1. Decedent's Name	e (First, Middle,	Last)			Timodic or i		2. Date of De			3. Time of Death	
Physicia /Medic				Frank	W.	Wi1	lis, Sr.		Februa	ary 13,2	009	7:44 A <sup>M</sup>	
Examin				give street and number)				Location of Death		4c. County		0.	
Funeral		5. Social Security No	umber 6	ry Drive	e (In yrs. la	a <i>st birthday</i>	If Under 1 Year	nda1k   If Under 24 Hrs.	8. Date of Bi	rth	timor	lace (State or Foreign	
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or 28g	Director	10e. Street and Num		,dr crimor c		-	10f. Zip Code			10g. Citizen of	What Count	ry?	
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r Item	Funeral	<ol> <li>Marital Status</li> <li>Never Marrie</li> </ol>	ed 2 <b>1</b> Married	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ I		5.   13.	Was Decedent of H If Yes, specify Cuba		ecity Yes or No Rican, etc.)	0- 14. Rac Bla	ce - America ck, White, e		
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permit. Tages I afford a Should be fined within 7.2 flours after beath with the Marynal Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examiner must be notified at once.		21. Signature of Fur	neral Service	Temsee	n		2. Name and Addres	ss of Facility Duc	la-Ruck	Funeral	Hom∈	of	
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this of	၉	1  Yes 2					nt 3 DOA Othe	4 LI Nursing Ho		idence 6 □Oth		)	
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier (Check only one)	1 ☑ Certifying 2 ☐ Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examinat	vledge, dea ion and/or i	th occurred at the tir nvestigation, in my o	me, date and place, pinion, death occur	and due to the ed at the time,	e cause(s) and made, date and place,	anner as sta and due to	ated. the cause(s)	
within To the comple	Med	29b. Signature and t	title of certifier	1 0			29c. License			29d. Date signe	d (Month, E	Pay, Year)	
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3+1		30. Name and addre	ess of person when BW	o completed cause of d	eath (Item	23a) (Type	Print) h Avenue	Suite 2	203 B	altmon	3 MI	) ZiZOR	
Sta		31. Date filed (Monti	h, Day Year)	8 2019 <sup>22. Registr</sup>	ar's Signati	ure A.	parket	-0110	- 10(	wer 11/10/10			
Registr	ar		The same of the sa										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician February 12, 2009 HILDEGARD WEBER рм 10:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Marner Health of Greater Laurel Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ F Months Days Hours Min. 7, 151-38-9821 July Director 1922 Germany Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1√2Yes 2 □ No MD Prince George's Laurel 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 14200 Laurel Park Drive 20707 or items 23a U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 XXIvo Specify: ģ Specify: 3 X widowed 4 ☐ Divorced White natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and 2 should be filed within 72 f Health and Mental Hydior fem 27 is mark-(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 11 Bookkeeper Publishing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Krah Martha Zimmerman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr William Karl Weber / P.O. Box 373, Walnutport, Pennsylvania 18088 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🛛 Kremation 3 ☐ Removal from State Arundel Crematory Feb 14, 200\$ 4 Donation 5 Dother (Specify) Odenton, Maryland 21. Signature of Funeral Service Icensee Bonaldsonsfuneral Home, P.A. a M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, of shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy l year Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Hypertension sician and burial-trans 10 years Due to (or as a consequence of): Box 68760 Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 □Yes 2 XXo Month Day 5 Other (specify) Ö 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2XXNo Physician: The certificate 1 □ Yes 2**X**XNo Division of Vital 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 XX ursing Home 5 Residence 6 Other (Specify) 2**X**XVo 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 1 X criffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one

within 2 To the

Michael Baako, M.D. 31. Date filed (Month, Day, Year) FFR 18 2000

29b. Signature and title of certifier

3450 Ft. Meade Road, Suite 209 32. Registrar's Signature ares

ttendin G

BHX21 CITY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29c. License number

D0057216

29d. Date signed (Month, Day, Year)

Feb. 13, 2009

Laurel, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 04690 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 12:15 AM 111/am 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death **Examiner** 159 more S.Mar 21229 55 treet 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) last birthday If Under 1 Year 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Hours Min L45 20 8550 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** MD altimoke 10g. Citizen of What Country? 10e. Street and Number 2123 or Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: A43-A45 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ₩idowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Shoeman Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Whinson (daughter) 11.25 Battimole Kevin Ka 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) of Funeral Service License 22. Name and Address of Facility 23a. Part1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 9 warms month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): sion of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cenelmo Vas 1**∑**Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 29a, Certifier DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Ste 200 Catonsville Maryland 21228 bernita 700 laylor mA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Part P

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

FEB 18 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10:00 PM 2009 Helen Wells /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Kosed Q Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Days Year) 1 □ M 2X F 217-20-8470 82 Director March 16,1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be redified at Baltimore Md. Edgemere 1 ☐ Yes 2 ☐XNo Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2902 Salisbury Ave. 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married レノピイS イドノピハ Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Bakery 10 years 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Health and Mental Oscar Mayer Anna Koska ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Daughter 38 Yew Road Essex Maryland Deborah Adam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20, 2009 Bel Air Memorial Belair Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk,
7110 Sollers Point Road, Dundalk, e of Funeral Service Licensee 21222 Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Meumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, s been signe should be c Completed by 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an seese page 2 autopsy performe 200016 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No monar funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20063327 FEB. 15, Wryst-HINET 2009 un mult 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIWOTIM D 9000 Franklin Squere Drive Bottimore, Md 21237 WOLDE 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Examin		4a. Facility Name (If not institution, give street and number			r Location of Deat	h	4c. Count	ty of Death	
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Funeral Director		5. Social Security Number 6. Sex 7 1 M 2 X F	. Age (In yrs. last birthda 84 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di March 7,	av. Year)	9. Birthplace (State or a Country) Maryland	Foreign
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the A	Director	10e. Street and Number	Dana	10f. Zip Code			10a. Citizen of	What Country?	
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after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2	! <b>_</b> XNo	If Yes, specify Cub. 1 ☐ Yes 2 🛣 No		to Rican, etc.)		ack, White, etc. ifv: White	
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Eventuers, and be retified at	2	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street	and Number or Ri	ural Route Numb	er. City or Town	n. State. Zin Code)	
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Page Jent of Int: If Iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)		Crematory		2009	Baltimo	ore City, MD.	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine 1: ust be refitted at once.		21. Signature of Funeral Service Licensee	1 n	22. Name and Addre			nında l k	D 7\	
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/Medical Examiner		resulting in death)  Due to (or	r as a consequence of):						
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	edical	29a. Certifier 1 ☐ Certifying Physician: To the b	est of my knowledge, de	eath occurred at the ti	me, date and place	e, and due to the	cause(s) and n	nanner as stated.	
the hin 24	Medi	one) and manne	r stated.						
7 wit	<	29b. Signature and title of certifier		29c. Licens				ed (Month, Day, Year)	
					9667			1-2009.	
2		30. Name and address of person who completed cause	or death (Item 23a) (Typ	e, Print)	os Colen	Boxie.	Maylan	6 21061	
Stat	te	31 Date filed (Month Day Year) 32 Ber	nistrar's Signature		3 (4)		•	~ 1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Whitaker 4a. Facility Name (If not institution, give street and number) 6.2009 /Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death Care altimore 24 Hrs Manor 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220-24-952 1 ☑ M 2 ☐ F 8 Director .28.1928 Usual Residence of Decedent Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Director 1 ☐ Tes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? N. Washington St.

12. Was Decedent Ever in U.S.
Armed Forces? U.S.A 21213 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Yes 2 No Specify. þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th ひらた Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) evy Whitaker, 19a. Informant's Name/Relationship (Type. Print) Blanche 2021 N. Washington St. Baltimore, MD 21213

ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 14☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ulaney Valley 2.12.2009 Baltimore, M.D. 22. Name and Address of Facility Vayon C. Greene Funcial Services 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, MD 21212 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be execute burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an page 2 autopsy performed Vital 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 | Inpatient Division or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 8813

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 18 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Williams 1:264 M  $\cdot 2009$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Itimore Dam If Under 24 H Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 ☐ F Months Davs Hours 219-40-4580 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Expression is ust by notified at Director MM 1 Tes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Dves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finand Mental H ည <u>) n Known</u> 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 27 Dorothy 1 20a. Method of Disposition Ave permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other t once. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date □Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Zion Butinore, MI 2.17.2009 22. Name and Address of Facility Vaugna C. Greene Fureral Services 21. Signature of Funeral Service Licenses 4905 York Ad Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) sud do /Medical Due to for as a consequence of) Examiner ion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the for use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the detached 9 Unknown signed by t d be detach Part I/Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 sl 24a. Was an of Vital 1 ☐Yes 2 ☐ No 2 = No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1No ျှ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attending Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eles som 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ECONDAD DEREVED MAD 31. Date filed (Month, Day, Year) Registrar's Signature State FEB18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** 10:00A \_eonard 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore St Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** March 19, 1927 Days Maryland 220-20-6059 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinations to included in 1 □Yes 2√No Director Maryland | Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 **USA** 626 Stevenson Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXVes 2 ☐ No WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2XXNo Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates þ 3 Widowed 4XXDivorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clerk Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 626 Stevenson Lane Towson, Maryland 21286 Son Dion Vallen Wright permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr
once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 25, 2009 Owings Mills, Maryland Garrison Forest Veterans 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service Ligensee 6500 York Road Baltimore, Maryland 21212 nnis 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEUNS **Physician** Coronan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \bigcap \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 26534

DHMH 17 Rev 1/2001

State

Registrar

Preme Drive #105 Jouson MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

120 Sister

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** OUNG FEB 5 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL BALTIMORE UNIVERSITY OF MARYLAND CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Days Months 027-14-9677 Yrs. MASSACHUSETTS Director OCT. 25 1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other thaumatic event, Its Morinal Examinar International 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 No Directo BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 830 W. 40th Street 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2⊠No Specify Specify: WHITE 2 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COLLEGE PROFESSOR 12th yrs 8yrs UNIVERSITY\_OF MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5324 Nightshade Ct., Columbia, Md. 21045 Malinda Orlin/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. METRO CREMATORY 02-18-09 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Service Deensee 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PERFORA'TION BOWEL disease or condition resulting in death) /Medical Due to (or as a consequence of) 1 day Examiner DIVERTICULITIS Sequentially list conditions, any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t rector, page 2 s autopsy performe 1∐Yes 2XNo 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) Director: After the in by the funeral 28h Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours a

To the Funeral C

completely filled i

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

22 32. Registrar's Signature

and manner stated.

29c. License number

P22935

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. GREENE BALTMORE MD 57. 31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar	State of Ma	aryiano		tificate of				eg. No.	200	9 04698
	sicia edica		Decedent's Name (First, Middle, Last,	Walter		Z	afia			2. Date of Deat Month Februar	Day	0, 2009	3. Time of Death 3:08P M
-	mine		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Locatio	n of Death		4c. (	County of Death	
			Gilchrist Center					owso				Baltimo:	
Fune Direc			193-10-0939	7. Age 7. Age 85		ast birthday) Yrs.	If Under 1 Year Months Days	Hours	er 24 Hrs. s Min.	8. Date of Birth (Month, Day, March 2	Year)	9. Birth Cou Per	place (State or Foreign intry) nnsylvania
and	24	1	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation			<u> </u>			10d. Inside City Limits
Maryl -f sho		ţo	Maryland Baltim	ore		,		]	Dunda1	k			1 ☐ Yes 2 🛣 No
r 28a		Director	10e. Street and Number				10f. Zip Code			1	0g. Citiz	en of What Cou	intry?
h with		<u>a</u>	8176 Delhaven Roa	d				21	222		Unit	ted Stat	tes
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5-UU36 72 hours aft natural", or	TVE	þ	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:	WWII	1	∐Yes 2X∑No	Speci	fy:			Specify:	√hite
<b>2-0</b>		etec	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>		16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during m	ost of workin	a	16b. Kin	d of Business/Ir	ndustry
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_ ~ = 0 :	1	Bec	17. Father's Name (First, Middle, Last)					18. Mo	ther's Name	(First, Middle, N	Maiden S	Surname)	Jnkn.
Viand  Vid be file Mental H  arked oth		၉	Michael Zafia						Marie				
Mar d 2 shc tth and 7 is m			19a. Informant's Name/Relationship (T)	· · · · · · · · · · · · · · · · · · ·		I a	g Address (Street						
e, n 1 and Health			Mr. John Zafia  20a. Method of Disposition	(S	on)	l	5 Todd Po						ryland 21219
ages and of little	2		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State			sition (Name of natory or other place		Da	İ		cation - City or T	
baltimo	ai l	-	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		Hil		ervice Co					wson, Ma	•
baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Ments important: If item 27 is marked	once		A CONS				Name and Addre						
			23a. Part 1. Enter the us ase, or coupl shock, or heart fail re.	cations that caused	the death	. Do not ente	922 Wise er the mode of dying	g, such	as cardiac or	respiratory arre	est,	Land 2.	1222 Approximate
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/Medi	_		resulting in death)	Due tr (or as	_		7 (7)						west-s
Examir	•	_	Sequentially list conditions,	).									
p ti		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mijury that initiated events	Due to (or as	a consequ	ence of):							
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tificat ug phy		edical											
ath cel	8	an/	Zob. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	v			2	3d. Date of deliv	/ery
Of VItal RECOIDS, F.O. BOX Physician: The law requires that the death cer this certificate has been signed by the attendir		hysician/N	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify) _	,				Month	Day Year
that the ed by		0	Part II. Other significant conditions con	ntributing to death bu	ut not resu	lting in the ur	nderlying cause give	en in Par	t I.	23e. Did tob	pacco us	se contribute to	the cause of death?
duires n sign		Completed by	Acute renal	FAILUX	e, Ì	Dein	entia	,		1 □ Ye	s 2 🖸	No 3□ Pro	bably 4 Unknown
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The is		mo	disease							autops: perforn	y ned?	prior to co death?	ompletion of cause of
VITAL ician: T		Be	25. Was case referred to medical examiner?					26. Pla	ace of Death	1 ☐ Yes 2 (Check only one		1 □ Yes	2 No
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Ing P		.: 0	27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry /, Year)	28b. Time of Injury	Worl	(?	į	3d. Describe ho	w injury	occurred	
VISION Attending ar death. ector: Afte		icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ury - At hou	me form etro		Yes 2		of Location (Ct	4	( N )	
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To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the		Medical	29a. Certifier 1 ☐ Certifying Phy cone) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best oner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	n occurred at the tir restigation, in my o	ne, date pinion, c	and place, a leath occurre	nd due to the ca d at the time, da	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
To the			29b. Signature and title of certifier	1.0			29c. Licens	e numbe	r	25	9d. Date	signed (Month,	Day, Year)
			1 Arthon	, the	)	m)	02	5	205	F	26	TUAN	111,2009
18	1		30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Type, I	Print) 0	CI	- Q-1	24. 100	1 -	2 ( 3 ) (	
54							Combe	ال و	. Dal	10.00	a <	1 60%	<u>-</u>
	Stat	е	31. Date filed (Month, Day, Year)	32. Registra	ars Signat	ure	_						

Registrar
DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **2**, **Physician** Helen Dorene ATHERTON 2009 10:00 p.M February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 965 Linwood Road Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Oct. 8, Birthplace (State or Foreign Country)
 Illinois Funeral Months Days Hours Min. 1 □ M 2 🛣 F 434-21-2549 51 Oct. 1957 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County show item 27 is marked other than "natural", or Items 23a or 28a-f shot other traumatic event, the "sedical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with i Hygiene. 21740 USA 965 Linwood Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No 2 Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Schaeffer Jeanne Smith ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum once. Berlyn Atherton - husband 965 Linwood Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2/3/09 Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ② Name and Address of Facility MINNICH FUNERAL HOME Signature of Funeral Service 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 20 mont disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed aftending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1∐ Yes 2⊡ No this Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ( mack 31. Date filed (Month) State Registrar

		_	For State Registrar	State of Marylar		rtment of H			iene <sub>eg. No</sub> 2009	04700
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat		3. Time of Death
	Physicia /Medic		Gloria	Tean	Ande	rson		Month	Day Year 29	6639 A M
	Examin		4a. Facility Name (If not institution, giv				Location of Death		4c. County of Dea	th
			MEMORIAL HOSPIME	@ CASTON		EASTON			74630	
	Funeral		5. Social Security Number 6. S	I M OFF		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	<ol> <li>Date of Birth (Month, Day,</li> </ol>	Year) Co	thplace (State or Foreign ountry)
	Director		291-24-1/12	62	Yrs.			JAn. 4,	1947 MO	ryland
	and	-	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation		···		10d. Inside City Limits
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Z	the 28a-	rec	10e. Street and Number	ester	Camb	10f. Zip Code		1	0g. Citizen of What Co	L
SS	3a or	Funeral Director	503 Muir Str	not Ant 3	307	21	613		USA	
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9	or ite		1 Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No		Tres, specify Cuba	Specify:	nican, etc.)	Black, Whit	e, etc.
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121	/ithin ne. han '	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)	i				0.1-1-11	Taluckey
CA	filed w Hygie other t	ပိ	12. Father's Name (First, Middle, Last	1	1/10	chini	18. Mother's Name	(First, Middle, I	「ひめいうれ」》 Maiden Surname)	19 + noustry
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	1 and 2 Health tem 27 other tr		20a. Method of Disposition		Place of Dispo	sition (Name of	1		20c. Location - City or	
ورزرم Imol	Pages nent of int: If it iry or o		1 ☐ Burial 2 🗖 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Removal from State	4 4 3	natory or other place Ye Cvema	1 7/4	7/09	Cambrid	es MD.
<i>G</i> <sub>L ολι</sub> α /η Baltimore,	# 돈 만 글 .	1	21. Signature of Funeral Service Lice			Name and Addre	ss of Facility			Je ivin.
Ba	Depa Impo any Ir		Janollo,	C. Slene	4) H	enry Fu	ineral I	tome, P.	Mbridge	MD 21613
			23a. Party. Enter the disease, or com	plications that caused the dea	ath. Do not ent	er the mode of dyir	ng, such as cardiac			Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	a centr	el inter	1 tran			9nset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a se	quence of):	· · · · · ·	9.01			hours
	Examiner		process and a second	Con	may A	rtery dise	asl			years
	D .±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	//					J
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hy	persention	<sup>t</sup> H				
50,	Attending Physiclan: The law requires that the death certificate be executed and each.  Actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	<u> </u>	resulting in deathy East	Due to (or as a conse	quence or):	nACK				
Box 68760	cate by physic the b	dical		d	ansire	W 712				
9 ×	ding l	/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy	-			22d Date of de	liver.
Bo	atten for us	ian	23b. Was decedent pregnant in the past 12 ments?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	ta⊦death 3 🏻	Ectopic pregnanc Other (specify)	ey .		23d. Date of de Month	Day Year
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rds	quires in sig uld be	g p	End stage	vonel disase				1 □ Y€	es 2 □ No 3 □ P	robably 4 Unknown
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ta	lan: '	Be C	25. Was case referred to medical				26. Place of Deat			2 2 110
<b>-</b>	nysic nis ce direc		examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Reside	ence 6 Other (Spe	ecify)
0 0	ng Pł fter tł neral	ü	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Wor	ry at k?	28d. Describe ho	ow injury occurred	
90	eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records,	or Att fter d irect in by	Certification: To	4 Homicide determined		home, farm, str cify)	eet, factory, office		28f. Location (S) City or Town	treet and Number or Fi n, State)	ural Route Number,
	pital burs a eral (		29a, Certifier 1 Certifying P	hysiclan: To the best of my kr	nowledge deat	h occurred at the ti	me date and place	and due to the o	ause(s) and manner a	s stated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		miner: On the basis of examir and manner stated.						
	To the To the Comp	Me	29b. Signature and title of certifier	Will yn		29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
	n			12 france	M		17177		2.20	1
	2		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	Print)	ane, Far	· L (1/1)	- 110	1
	-04	t a	31. Date filed (Month, Day, Year)	32. R <b>9g</b> istrar's Sigr	/IAM	mens L	ane, tas	10n, /vs	100	/
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			1 - For State Registrar	Otate of Marylan		rtificate of		_	Reg. No.	2009	04702
	Physici	an	Decedent's Name (First, Middle, Last,     Orville McLe					2. Date of De Month		Year	3. Time of Death
- Lag	/Medic	cal	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deatl	01	4c. 0	County of Dear	1,00(A M
ne de	LAGIIII	ic.	Coastal Hogace	1.1-	(e_	Sal	sbur	<i>Y</i>			mico
	Funeral Director		5. Social Security Number 6. Sec 230-03-7603 10	x 7. Age ( <i>In yrs.</i> <b>X</b> M 2□ F 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 07/10/	a <i>y</i> , <i>Year)</i>	Co	thplace (State or Foreign ountry) /irqinia
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	e Mary	ctor	Maryland Wicomic	o Sal	isbury						1 X Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if the Medical Exeminar must be nutified at once.	Funeral Director	10e. Street and Number 200 Civic Ave.			10f. Zip Code 21804	4		10g. Citiz USA	en of What Co	ountry?
	items ?	uner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	D- 1	4. Race - Ame Black, White	
036	urs afte al", or i Examir	þ	1 ☐ Never Married 2 ☐ Married 3 🕇 Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	16	1∐Yes 2XINo	Specify:			Specify:	white
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212	d within giene. er than	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		gement			C	onstru	ction
and	d be file antal Hy sed oth c event	Be	17. Father's Name (First, Middle, Last) Wiley young Ander	son			18. Mother's Nan	ne (First, Middle Irene			
Maryland	2 shoult and Me Is mark aumati	2	19a. Informant's Name/Relationship (Ty	vpe. Print)			l t and Number or Ru	ıral Route Numb	er, City or	Town, State, 2	
e, N	1 and Health em 27 other tr		Will Farrar/grand  20a. Method of Disposition			sition (Name of	cean City	Date		ation - City or	
Baltimore,	Pages nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	hatory`or other pla le Cemete	, ,	8/09		tsville	
Balti	permit. Departr Importa any Inju	4	21. Sunature of Funeral Service Licens			Name and Addre	Funeral I	Home Pro	fess	ional A	Association
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	idations that caused the death			Hill Rd.,			MD 218	Approximate Interval Between
	e executed /Medical an and itial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as e consequence)	uence of):	ARKINI SPIRAT	SONS G	PRSRA.	5 P2	iAs	Onset and Death
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of Vital Records,	w requir s been s should	Completed						24a. Was		24b. Were au	utopsy findings available
E Re		Comp						auto perfo 1 ∐Yes	psy ormed? 2 ANO	prior to death? 1 □ Yes	completion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ED/O	. all post lott	26. Place of Dea				u thenian
	e le	on: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	I 3 LI DUA	4 LI Nursing H	ome 5 ☐ Resi 28d. Describe		Other (Spe	city) HOSPICA
Division	at at	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specifi	ome, farm, str	M 1 🗆	]Yes 2□No	28f. Location (	Street and	Number or Ru	ural Route Number,
Ö	를 를 들		4   Nothicide					City or To			
	e Hospital 24 hours a e Funeral I letely filled	Medical	29a. Certifier (Check only one)  7 CertifyIng Phy 2 Medical Exami	slcian: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death ition and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)
	To the P within 24 To the F complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date	signed (Monta	h, Day, Year)
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	11.0		30. Name and address of person who co	1 COASTAL -	Hospi	CE PUB	ox 173	1 SAT	is Br	ung n	021802
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture .	border	,			/	

			1 - State OF IVI		rtificate of	Death	Reg. No. 2	09	04703
П	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Month	Death Day	Year	3. Time of Death
	/Media		NOHAD ABOULHOSSON		Т		ary 5, 20		6:20 P M
	Examir	er	4a. Facility Name (If not institution, give street and number)		1	r Location of Death	4c. Coun	ity of Death	
يُلا			Joseph Richey Hospice  5. Social Security Number 6. Sex 7. Aq	e (In yrs. last birthday)	Baltimo:		Dieth	I O Disaber	100- (0)
	Funeral Director		590-19-8030 1 M 2 M F V Sual Residence of Decedent	81 Yrs.	Months Days	Hours Min. (Month)	Birth Day, Year) /1927	Lebar	lace (State or Foreign try) non
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Man)	tor	Virginia Fairfax	Springfi	.eld				1 □Yes 2 No
	or 28g	Director	10e. Street and Number	1 0	10f. Zip Code		10g. Citizen o	f What Coun	try?
	th wit		6604 Edsall Road		2215	1	Lebar	ion	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is the Event in the injury of other traumatic event, it is the Event in the injury of other traumatic event, it is the Event in the injury of other traumatic event, it is the Event in the injury of once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☒ If Yes, Give Year or Dates:	No.	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛣 No	dispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	No- 14. Re BI	ace - Americ ack, White, e	etc.
9	atura	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation	16b. Kind of		
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<u>ya</u>	Meni Meni arked aric e	ပ္	Kassim Aboulhosson			Hafitha Ackley			
lar.	2 sho and is m raum		19a. Informant's Name/Relationship (Type. Print)			and Number or Rural Route Nu			,
e)	and Health Im 27 Ther t		Kamal Aboulhosson - Son			d.,Springfield,	<del></del>		
Baltimore,	ges 1 nt of H If ite or ot		20a. Method of Disposition 1   □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren			20c. Location	-	
ŧ	t. Pa rtmer rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)			ry  02/08/2009			
Ba	Depa Impo any ir		21. Signature of Funeral Service Licensee	M01080 8	2. Name and Addre	ss of Facility Found & a ey Rd., Manassas	Sons - Le ,Virgini	e Cha .a 201(	pe1 09
	icate be executed  /Medical Examiner  the prival-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ie. ,/	1	WASEVUAL D			Approximate Interval Between Onset and Death
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	thin 3 the omple	Med	one) and manner sta	ted.	29c. License				
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•		-	30. Name and address of person who completed cause of de	MD (Normal)	USE	211	0403/8	29	
			30. Name and address of person with completed cause of de	R No Figure 1	Ken Sand	BANTIMORE, 1	מרור על	,	
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		State Registrar	e of Marylar		tment of <i>ificate of</i>		ivientai		Reg. No.	200	9	047
hysicia	an/	<ol> <li>Decedent's Name (First, Middle,La</li> </ol>					3 2	2. Date of De Month	Day	Year	3. Time of 1925	
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		4a. Facility Name (if not institution, g Malcolm Grow Hospital	ive street and num	iber)		Riverdale	ocation of Be	auı		ce George		
uneral		Social Security Number 6.3	Sex 7	. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of E	Birth (MM/DD/Y			ate or
irector		577-98-0529 1	XM 2 F		35 Yrs.	Months Days	Hours h	vin. Dec	.31,19	Foreig 973 <sup>Co</sup>	₩ash	, DC
		Usual Residence of Decedent										
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f sho	ğ	DC		7	Vashin				10g. Citizen	of What Cou		
or 28a-f show fied at once.	Director	10e. Street and Number	"04			10f. Zip Code						
nous and used one at 7.3 or 188-f sho Exact aler must be notified at once.		3549 Jay St.,		dent Ever in U.S	13 Wa	2001 s Decedent of His		Specify Yes or I		ted S		
items	Funeral	1 Never Married 2 Marrie	ed Armed For	ces?	If Y	es, specify Cuban,	Mexican, Pue	erto Rican, etc.)		White, etc.		
Tr, or		3 Widowed 4 Divorce	1 Yes	2 X No	1	Yes 2X No	specify:		Spe	cify: Bla	ck	
ate :	d by	15. Decedent's Education (Specify	or Dates: only highest grade	completed)		t's Usual Occupatiost of working life.			16b. Kind	of Business/	Industry	
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and 2 Shourd be titled within 72 realth and Mental Hygiene.  teu 27 is marked other than " traumatic event, the Medical	To B	19a. Informant's Name/Relationship			19b. Mailing	Address (Stree	t and Number	or Rural Route N	umber, City or	r Town, State	e, Zip Code	•)
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pennin, rages in Department of Hambortant: If injury or other		21 Ognature of Funeral Service Lic			22. N	Name and Address	of Facility H	lodges	& Edwa	ards	F.H.	
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he Hospital or Attending Physician: The law ro in 24 hours after death. he Finicial Director: After this certificate has bo bletely filled in by the funeral director, page 2 sho	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ  29a Certifier 1 Certifying Physics	gation anot be inned (Specify)	t of my knowledg	ge, death occu	urred at the time, d	ate and place,	or Tow	n, State)  ause(s) and m	nanner as sta	ated.	3)
ospital or Attending Physician: The lan hours after death. nueral Director: After this certificate ha y filled in by the funeral director, page 2	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ  29a Certifier 1 Certifying Physical Exami	gation anot be inned (Specify)	t of my knowledg	ge, death occu	urred at the time, d	ate and place,	or Tow	ause(s) and nate and place,	nanner as sta and due to e signed (M	the cause(s	
to the trospital or Attending Physician: The law re within 24 hours after death.  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sho		2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ  29a Certifier 1 Certifying Physics	gation 28e. Place (Specify) rsician: To the besiner:On the basis of	t of my knowledg	ge, death occu	urred at the time, d	ate and place, n, death occur se number	or Tow	ause(s) and mate and place,	and due to	the cause(s	
to the trospital or Attending Physician: The law re within 24 hours after death  To the Finteral Director: After this certificate has be completely filled in by the funeral director, page 2 sho	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ  29a Certifier 1 Certifying Physical Exami  29b. Signature and title of certifier	gation not be inned (Specify) sician: To the besiner:On the basis of and manner st	t of my knowledge of examination al tated.	ge, death occu	urred at the time, d ation, in my opinion 29c. Licens	ate and place, n, death occur se number	or Tow	ause(s) and mate and place,	and due to	the cause(s	
10 the Hospina or Attending Physician: The law re within 24 hours after death  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sho	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ  29a Certifier 1 Certifying Physical Exami	gation not be inned (Specify) sician: To the besiner:On the basis of and manner st	t of my knowledge of examination at tated.	ge, death occund/or investiga	urred at the time, d ation, in my opinion 29c. Licens	ate and place, n, death occur se number M.E.	or Tow , and due to the c red at the time, d	ause(s) and mate and place,	and due to	the cause(s	
	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide  29a Certifier 1 Certifying Physical Exami  29b. Signature and title of certifier  30. Name and address of person w Melissa Brassell, MD	gation not be inned (specify) sician: To the besiner: On the basis of and manner significant dependence of the completed cause.  Assistant Mereconduction of the completed cause.	t of my knowledge of examination at tated.	ge, death occu nd/or investiga 23a) ner 111	urred at the time, d ation, in my opinior 29c. Licens O.C.	ate and place, n, death occur se number M.E.	or Tow , and due to the c red at the time, d	ause(s) and mate and place,	and due to	the cause(s	

			State of Maryla <b>1</b> _ State		partment of H e <i>rtificate of L</i>			-	200	10	01.	705
	_		Registrar  1. Decedent's Name (First, Middle, Last)		or timeate or E	Jean	2. Date of De		201	77	3. Time of I	Death
	Physicia		Robert LeRoy Byrd, Jr.				Month Januar	Day	Ye 20	n a		ОРМ
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Janoar		County of E			
	LAAIIIII	61	Washington County Hospital		Hagerst	own		Wa	shing	ton	Count	у
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v Year)	9.	Birthpla	ce (State or	Foreign
	Director		230-01-7591 1 <sup>™</sup> 2□ F 87	Yrs.	World's Days	Hours Will.	Dec. 18	3,192	1 Vi	rgi	nia	
	p		Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or l	ocation					100	1. Inside Cit	v Limite
	shov shov	'n								1100	1 □Yes	
	28a-f	Director	10e. Street and Number	gersto	10f. Zip Code			10a Citiz	en of Wha	t Countr		-31
	with with	ā			· ·					Count	у.	
	eath	Funeral	9940 Premiere View Circle  11. Marital Status 12. Was Decedent Ever in U	U.S. 13	21740 B. Was Decedent of Hi		ecify Yes or No	U.S.	A . 4. Rac <i>e - i</i>	America	n Indian.	
0	rer d	Fur	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ WO		B. Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)		Black, V	Vhite, etc	2.	
0000	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show dical Examinatination in difficut at	ρ	3 M Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 □Yes 2 <b>X</b> No	Specify:		3	Specify: [	Mite	≘	
<b>?</b>	2 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupa e kind of work done d	ation	ina	16b. Kin	d of Busin	ess/Indu	stry	
V :	thin thin the second se	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life.	. DO NOT use retired,	)	,,,9	_				İ
7	ed wi ygier <b>ner</b> th		1	Manag	ger				1y Co	mpai	ıy	
	be til	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			urname)			
<u> </u>	narke	ဥ	Robert L. Byrd, Sr.	401 14		Ethel Ma			T 0:			
	th and		19a. Informant's Name/Relationship (Type. Print)		iling Address (Street a							
บ้	1 and Healt em 2		Patricia R. Young-daughter  20a. Method of Disposition 20b.		O Premiere position (Name of ematory or other place		cie Has		OWN , ation - City			
2	ages ant of t: If It		I I A Buriai 2 🗀 Cremation 3 🗀 Hemoval from State I		ematory or other place s Cemetery	:	-2009	Mana				
Dallinor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inpopartment of Health and Mental Hygiene. Inpopartment of Health and Mental Hygiene. Inpopartment is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be indifficult anonce.		4 ☐ Donation 5 ☐ Other (Specify) M6  21. Signature of Funeral Service Licensee		22. Name and Addres		uglas A				ral Ho	me
۵	Depar Impo any ir		1) June la Attinu		1331 Easte		0		•			
П		/	23a. Part 1. Enter the disease, or complications that caused the dea								Approximate	
F	hysician		shock, or heart lilure. List only one cause on each line. Immediate Cause (Final disease or condition	Gara	Liver	Nisea	10				Donset and D	
	/Medical		resulting in death)  a.  Due to (or as a conse	equence of):	CVCY	111300					407	
E	Examiner		Securation list and disease by Chym	ick	-iducy	Disea	se				5'x	:
-	g #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of):	O							
	and trans	Kam	Cause (Disease or injury that initiated events c	augus of						_		
Š .	physician and the burial-transit	al E	resulting in death) Last Due to (or as a conse	quence or).								
00/00	p phys	ledical	d									
5	attending p	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23	3d. Date of	f deliver	,	
Ó	d for 1	iciai	in the past 12 months? 1 □ Live birth 2 □ Fe		B □ Ectopic pregnancy 5 □ Other <i>(specify)</i>	<u>'</u>			Month			ear
)	by the	Physician/M	9 Unknown									
ה .	gned gned	by P	Part II. Other significent conditions contributing to death but not re	sulting in the	underlying cause give	n in Part I.	23e. Did to	obacco us	e contribu	te to the	cause of de	ath?
Spics	equire	ted					1 🗆 '	res 2□	No 3[	] Probal	oly 4 TOU	nknown
ָ ט	as be	Completed					24a. Was		24b. Wer	e eutops	y findings a	vailable use of
ב =	rne ate h page	Son						rmed? 2 No	deat			
Ta	cran: sertific sctor,	Be (	25. Was case referred to medical examiner?		I au	26. Place of Death	(Check only o	ne)				
5 8	this cal dir	70	1 Yes 2 No Hospital: 1 Appatient 2	ER/Outpati		4 LI Nursing Ho				Specify)		
	Attending Prystotan: The law requires man the of ar death.  ector: After this certificate has been signed by the by the funeral director, page 2 should be detached	ion	27. Manner of Death  1 ☑Natural 5 ☐ Pending (Month, Day, Year)	Injury	Work	rat ? res 2 □ No	28d. Describe l	now injury	occurred			
	deatl deatl ctor: y the	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At 1	home, farm, s			28f. Location (5	Street and	Number c	r Rural i	Route Numb	ner.
2	after Dire d in b	Certification:	4 Homicide determined building, etc. (Spec	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tov	vn, State)			10010	.,
	to the ropetal or Attending Prysician: The law requires that the deam certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr  2 Medical Examiner: On the basis of examination and manner stated	nowledge, de nation and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occuri	and due to the red at the time,	cause(s) a	and mann	er as sta due to t	ted. he cause(s)	
	ithin 2	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License	number		29d. Date	signed (N	fonth, Di	ay, Year)	
	- s ⊨ ö			pp.m.s	85	2323		01-	- 5 3		2000	q
			30, Name and address of person who completed cause of death (Ite	 em 23a) (Type	e, Print)	. , ^		: 1		-		1
51	1-5		Muhanmad Waseem	1 M	0 1126	Opal C	Just	1+0	19015	stolic	n Mi	12174
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature								
D1	Registr		FEB 0 3 2009 Same	1.	pare							
THIN	H 17 Day 1/0/	101			-							

			1- For Amend Item 5 Sta State Registrar WCHD/SH 2/3/09	te of Maryland / D	epartmen Certificat	t of Hea e of De	aith and eath		giene (	9 (	14706
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
E	/Media		Maude Cathryn Brittai					January	28 200	9	4:30 A M
3	Examir	ner .	4a. Facility Name (If not institution, give street a	nd number)			cation of Dea	ith		4c. County of Death Washington County	
-	Funeral	E ,-•	Coffman Nursing Home  5. Social Security Number 6. Sex	7. Age (In yrs. last birth		erstov	WII Under 24 Hr		h		
132	Director		187-09-7/24 <sup>4</sup> 1 M 20	91 Y	rs. Months	Days H	Hours Min	Oct. 2	y, Year)		e (State or Foreign ) 1vania
	put *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Lagation						
	Aaryla Febo	ō	Maryland Washington C							100.	Inside City Limits 1 XYes 2 No
	28a-	Director	10e, Street and Number	ouncy magerst	10f. Zip	Code			10g. Citizen of W	hat Country	
	3a or	Ö	1304 Pennsylvania Ave	•		21742			U.S.A		•
	deat ms 2	Funeral	11. Marital Status 12. Wa	Decedent Ever in U.S. ed Forces?	13. Was Dece	dent of Hispa	inic Origin? (	Specify Yes or No	14. Race	- American	
36	or It	by Fu	1 Never Married 2 Married 1	Yes 2 XVo	1 🗆 Yes		Specify:	nto ritoari, etc.,	Specify:	t, White, etc.	
Ö	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ehow idical Examinar must be notified at	d ba	3 ₩idowed 4 Divorced Year  15. Decedent's Education	r or Dates:	Decedent's Usua	al Ossupation				MILT	
15	S 2 3	Completed	(Specify only highest grade comp.	eted) (	Give kind of wo life. DO NOT us	rk done durir	ng most of wo	orking	16b. Kind of Bus	siness/indus	try
212	giene.	mo:	8	ege (1-4or 5+) Hou	sewife				Persona	al Res	idence
pu	be filed tal Hygid d other event, ti	Be (	17. Father's Name (First, Middle, Last)			18.		me (First, Middle,		))	
yla		ပ္	Albert Clayton Bricke					Shaffer			
Maryland 21215-0036	0 8 8 0		19a. Informant's Name/Relationship (Type, Print)					lural Route Numbe	•		de)
<u>6</u>	1 and 2 Health tem 27		Charlotte Ann Martin—c	20b. Place of I	Disposition /Nan	ne of	rike C	lear Spri	ng, MD 2		State
ē			1 XBurial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State cemetery	crematory or o Lawn Me	ther place)	de 1-31	1-2000			
Baltimore,	그 된 본 글		21. Signature of Funeral Service Licensee	Cedai				ouglas A.	Hagersto	own, M	aryiand 1 Homo
ä	Department Department		Demola Ax	>·	1331 E	astern	Blvd.	North H	lagerstov	vn. MD	21742
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf-failure. List only one-cause on right line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.							rest,	tnt	proximate erval Between sset and Death		
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of ue to (or as a consequence of	(						
P.O. Box 6	that the death certific ed by the attending pi detached for use as t	Completed by Physician/Medical	in the past 12 months?	s, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 □Ectopic pro				23d. Date Mont	of delivery h Day	y Year
Division of Vital Records, P	w requires that the s been signed by th should be detache	ed by P	Part II. Other significant conditions contributing	g to death but not resulting in t	he underlying co	ause given in	Part I.	23e. Did to	bacco use contrib		ause of death?
900	law re	piet	/	7				24a. Was		ere autopsy	findings available
<u> </u>	The taw ete has b page 2 si	E C						autop perfor	med? de	ath?	etion of cause of
Vita	lcien: Sertific Sector,	Be	25. Was case referred to medical examiner?				. Place of De	ath (Check only or	18)		
of	Physicien: this certific ral director,	2:	1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outp Date of Injury 28b. Tin			Wursing H	lome 5 Resid			
O	ding h. After funer	fon	1 Pending 5 Pending	Date of Injury 28b. Tin (Month, Day Year) Inju	Jry M	8c. Injury at Work?	2 🗌 No	28d. Describe h	ow injury occurre	d	
/isi	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	Place of Injury - At home, farm			2   140	28f. Location (S	treet and Number	or Rural Ro	oute Number
Ö	al or A s after of Dire	Sert	4 Homicide determined	building, etc. (Specify)	,,,	,		City or Tow			
	To the Hospital or Attending Physicien: The law Within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai (	Check only 2 Medical Examiner: On	o the best of my knowledge, the basis of examination and/manner stated.	death occurred a or investigation,	at the time, d in my opinio	late and place in, death occu	e, and due to the curred at the time, c	ause(s) and mani late and place, ar	ner as stated and due to the	d. cause(s)
	To the within 2 To the complei	Ž	29b. Signature and title of certifier		290	. License nui			9d. Date signed		
			* SAMUEL CLAN	/	0	7669	5	7	An 29	200	19
4	4-2		30 Name and address of person who completed	cause of death (Item 23a) (Type STALL)	ype, Print) FUITE	200	HA	ultur	(M)	274	0
	Stat Registra	i.e	31. Date filed (Month, Day, Year) FEB 0 3 2009	32. Pegistrar's Signature	bores	,					

	For State of Maryland / I	Department of Health and Mental F Certificate of Death	Reg. No. 2009 04707					
Physician	1. Decedent's Name (First, Middle, Last)  CORA M. BOND	2. Date of Month	Death 3. Time of Death Day Year					
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
Funeral Director	DOCTORS COMMUNITY HOSPITAL  5. Social Security Number  6. Sex 1 □ M 2 ☒ F  83	Months Days Hours Min. (Month,	PRINCE GEORGES  Birth Day, Year)  9. Birthplace (State or Foreign Country)  21,1925 WASH. D.C.					
and	Usual Residence of Decedent   10a. State   10b. County   10c. City, Tow.	n or Location	10d. Inside City Limits					
Maryl Fied a			1 ⊈Yes 2 □ No					
or 28a-f st be notified Director	10e. Street and Number	HYATTSVILLE  10f. Zip Code	10g. Citizen of What Country?					
th wit	5805 42nd AVE. #423	20781	U.S.A.					
and 21215-0036  be filed within 72 hours after death with the Maryland tital bygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be northed at Be Completed by Funeral Director	If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □Yes 2 ☒️No Specify:	No- 14. Race - American Indian, Black, White, etc.  Specify: WHITE					
5-0 5-0 72 ho	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry					
A A R C 21215-00 ed within 72 hou ygiene. The medical E t, the medical E Completed	Elementary/Secondary (0-12) College (1-4or 5+)	iffe. DO NOT use retired)  TELEPHONE OPERATOR	C&P TELEPHONE CO.					
nd ind ind ind ind ind ind ind ind ind i	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd						
yland yland yland ould be file merked oth narked oth	GEORGE ROBEY	GLADYS	LITTLE					
Mai Mai d 2 sh Ith and 17 is n		. Mailing Address (Street and Number or Rural Route Num						
Bob (A) (A) (A) (A) (A) (A) (A) (A) (A) (A)	20a. Method of Disposition 20b. Place of	B05 42nd AVE. #423, HYAT Disposition (Name of y, crematory or other place)	20c. Location - City or Town, State					
RC Lastimo altimo nii. Page artment cortant: If injury or e.	TE Bullat 2 Actellation 3 El Hellioval Iloni State	BERS CREMATORY 1-30-2009	RIVERDALE, MD.					
Baltimore, Maryland 212:  Baltimore, Maryland 212:  permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mone.  To Be Comp	21. Signature of Funeral Service of Insee  M0009  23a. Part 1. Enter the disease, or complications that caused the death. Do	22. Name and Address of Facility CHAMBERS FUNERAL HOME & 1 5801 CLEVELAND AVE., RIV	CREMATORIUM,P.A. VERDALE, MD. 20737					
68760, tifficate be executed physician and as the burial-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions).  Due to (or as a consequence of the conditions).  Due to (or as a consequence of the conditions).	9- 	Onset and Death					
Box (eath certification of the saturation of the	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year					
cords, P.O. w requires that the di sheen signed by the should be detached	Part II. Other significant conditions contributing to death but not resulting in		d tobacco use contribute to the cause of death?  ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
Division of Vital Records, and attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be detrification: To Be Completed by		24a. Wa aut per 1 □ Yes	topsy prior to completion of cause of death?					
Vity	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Lepatient 2 ☐ ER/Ou	26. Place of Death (Check only						
Division of tall or Attending Phys rs after death.  Tal Director: After this led in by the funeral directors after Certification: To	27. Manner of Death 1	tripatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  Time of njury M 28c. Injury at Work?  M 1 Yes 2 No 28d. Describe how injury occurred						
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	(Street and Number or Rural Route Number, own, State)						
o the Hosp ithin 24 hou o the Fune ompletely fi	29a. Certifier  (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
<b>3</b>		- MDD58182	1-28-2009					
	30. Name and address of person who completed cause of death (Item 23a) ( CCC) D. GEOVGE 7500 Hr	Type, Print) two ver far Kway Suite II 101	A Greenhelt mo 20170					
State Registrar	31. Date filed (Month, Day, Year)  10 N 3 0 2009  32: Jegistrar's Signature	hall	0					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LAWRENCE BURKE JANUARY 28 2009 17:53P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F 220-40-3531 22 1942 **Director** Dec. Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar must be notified at Director Md. Montgomery Brookeville 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or namy Injury or other traumatic event, the Medical Examinat rough bonge. 19021 Heritage Hills Drive 20833 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician Dental Laboratory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Burke Margaret Kelly ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane S. Burke / Wife 19021 Heritage Hills Drive, Brookeville, Md. 20833 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2/4/09 Alexandria, Va. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signatur of Funeral Service Licensee -004170 P. O. Box 5038, Laytonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2NONTT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of): Dívision of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 🗆 No 1 □ Yes Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 DM6 1 Depatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital within 24 hours a 1 Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) ROCKLEOGE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 4:45 аМ Marve1 Francis Bowar January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Min. | Mar. 05, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 390-14-3584 85 1923 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14805 Pennfield Circle #310 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:1943–46 1 ☐ Never Married 2 ☑ Married Specify: Caucasian 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Military Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Command Systems, Pentagon 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph F. Bowar Lavona Winkler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pennfield Circle #310; Silver Spring, MD 20906 Mamie Joan Bowar / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Lincoln Crematory 2/03/2009 21. Signature of Funeral Se 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enjerthe diseas , shock, or part failure. Lift Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line YTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2€ No 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗋 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed as the burlal-tran P.O. Box 68760, cate has been signed by the attending p page 2 should be detached for use as Division of Vital Records, ours after death.

eral Director: After this certificate I filled in by the funeral director, page within 24 hours a

**Physician** 

/Medical

Examiner

Directo

by Funeral

Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

29a. Certifier

29b. Signature and title of certific

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Express.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

To the

	30. Name and address of person who complete SAYED ELSP	leted cause of death (Item 23a) (Type, Print) 144AID 10110 MaleCular	Dr. Roctville	, MD 2085
State egistrar	31. Date filed (Month, Day, Year) FEB 0 3 2009	3. Registrar's Signature		

and manner stated.

🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:31 am January 27, Poteat Boughman 2009 Wavne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Casey House Rockville KOCKVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□ F Yrs. 1931 **Director** 237-42-7651 May 25, North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaniner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Gaithersburg Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8120 Exodus Drive 20882 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces of 1 ⊠Yes 2 □ No If Yes, Give Korean Year or Dates. War\_ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Caucasian <u>و</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer 3 Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Guv Boughman Poteat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8120 Exodus Drive; Gaithersburg, MD 20882 Doris L. Boughman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 2/03/2009 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Et er the disease, or complications that caused it shock, if heart failure. List only one cause on each line. Immediate varies (Final disease or condition resulting in death)

Pancreat: Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Pancreatic Cancer /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for an a nonneguenne of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hean cinned he the hours. Diabetes Mellitus attending physician and for use as the hirial-tra-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Superior Mesenteric Vein Thrombosis IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s autopsy performed? 1 ∐Yes 2 KINo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$  Other (Specify)  $\square$  Hospice 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XX Natural 5 ☐ Pending investigation i after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20063748 ROUATEHOU, mD JOCEK Jan. 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne T. Kouatchou, M.D. 201 East University Pkwy, Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 03 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤿 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 31, 2009 Dorothy Elizabeth Bonk January 8:17 p /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs. ] Date of Birth (Month, Day, Ye 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours 204-28-7028 Feb. 71 1937 Director Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show items 23a or 28a-f sho Directo 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 517 Harding Drive 20901 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married ir than "natural", or i altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene.

27 is marked other than "r traumatic event, Inc. Elementary/Secondary (0-12) College (1-4or 5+) 4 Special Education Teacher Catholic Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Peter Bonk Helen Mary Ustaszewski ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 517 Harding Drive, Silver Spring, MD 20901
e of Disposition (Name of Date 20c. Location - City or Town, State Helen T. Bonk/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 5, Feb. Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring. MD 2090 23a. Part 1. Enter the disease, or complications that Sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 2 No Month Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ icate has been si , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes No. 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records,

P.O. Box 68760

24 hours a To the within 2

State Registrar

Medical

29a. Certifier

29b. Signat

(Check only one)

30. Name and address of person

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D24348

1.31.2009

who completed cause of death (Item 23a) (Type, Print) MD

and manner stated.

Forest Glen Rd. Silver Spring MD 20910 1500

31. Date filed (Month, Day, Year) FEB 03

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death Month Year 9:00 p.M Lewis Charles Buchman January 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death William Hill Manor Easton Talbot If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F 101-22-4105 81 July 17, 1927 New York Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Talbot 1 Xes 2 No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 E. Dover St., #308 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) president/owner garment mfg. 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Buchman Fannie Block 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Buchman wife 117 E. Dover St., #308, Easton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State National Memorial Pk.: 2/1/09 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jyens disease or condition resulting in death) helme Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bolism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 No 1 ☐ Yes 2 □No 25. Was case referred to medical 26. Place of Death (Check only one)

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial attending physician for use as the buria signed by the a

Box 68760.

P.O.

Records,

Division of Vital

Physician

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

or items 23a or 28a-f

"natural"

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event

Director

Funeral

2

Completed

Be

ပ

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

1∐Yes 2☑No

27. Manner of Death

2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

1 Natura

MD

injury or other traumatic event, the Mudical Expressure roust be notified at

Baltimore, Maryland 21215-0036

page 2 should certificate After this certification funeral director, p n 24 hours after death, e Funeral Director: Af eletely filled in by the fur

completely To the I within 2.

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

> > 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey T. Denton, M.D. 555 Cynwood Drive, Easton, MD

31. Date filed (Mon

6 ☐ Could not be

determined

32. legistrar's Signatur

Registrar

		State of Maryland / Department State		lental Hygie	ene
		Registrar	rtificate of Death		.No. 2009 04/13
Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
/Medic		John Vernon Baggett  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	30, 2009   4:35 A M
Examin	er	40924 Lake & Breton View Drive	Leonardtown		St. Mary's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
Director		219-10-0462 1™ 2□ F 83 Yrs.	Months Days Hours Min.		1925 Maryland
pu >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
laryla shov	o				1 ☐ Yes 2 ☐XNo
the N 28a-1	Director	Maryland St. Mary's Lo	eonardtown 10f. Zip Code	10a	. Citizen of What Country?
with 3a or		40924 Lake & Breton View Drive	20650		USA
death ms 2	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
and 21215-UU36  be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the "dicht Evan free met be notfiled at	by Fu	1 □ Never Married 2 15 Married 1 15 Yes 2 □ No	n Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	rican, etc.)	Black, White, etc.  Specify: White
Z15-UU36 thin 72 hours aft e. an "natural", or m die el Evani		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	b. Kind of Business/Industry
bin 72 37 min 72 30 min 73	Completed	(Specify only highest grade completed) (Give life.	kind of work done during most of worki DO NOT use retired)	ng	
Ad with	Con		ector of Parks & R		County Government
land ld be file fental Hy ked oth ic event	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		
Maryland 2121 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, in Men	မ	John Henry Baggett	Bertha		riffith
re, Maryla s 1 and 2 should f Health and Mer tiem 27 Is marke other traumatic					City or Town, State, Zip Code) 20650
1 and 1 and		20a Method of Disposition 20b. Place of Dispo			c. Location - City or Town, State
noi ages ent of ht: If if		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Charles 1	matory or other place)	/2009 Le	eonardtown, MD
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra			2. Name and Address of Facility Bri		
Depariming any ire		I would be to the total of the	22955 Hollywood Ro		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate
Physician		Immediate Cause (Final disease or condition EsoPhayo 995	tric (ancer u	vity m	etusteuis 2 months
/Medical Examiner		resulting in death)  Due to (or as a contraction of):			
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
cuted nd ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events  c			
e exe	EX	resulting in death) Last Due to (or as a consequence of):			
I RECORDS, P. O. BOX 68/60,  The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d			
x certific ding page as	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			T
BOX eath cer attendir for use	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 L 9 ☐ Unknown 9 ☐ Unknown	2 Other (apoutly)		
b that		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
quire:	q pa	Hypertension		1 □ Yes	2 No 3 Probably 4 Unknown
HECOIGS,	Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The ate h	E			performed	death?
VITAL Ician: T certificat ector, pa	Be (	25. Was case referred to medical examiner?	26. Place of Death		
ohysi this c	မ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			ce 6 Other (Specify)
INVISION OI  I or Attending Phy after death. Director: After this d in by the funeral d	ion	27, Man of Death  1 ✓ Natural 5 ☐ Pending (Month, Day, Year)  28b. Time of Injury	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred
Vittence death death ctor:	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Stree	et and Number or Rural Route Number,
al or / after after Dire	Certification:	3 ☐ Suicide determined determined determined determined determined determined building, etc. (Specify)		City or Town, S	
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
o the ithin 2 o the omple	Med	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
F 3 F 8	-	> hudulin	D0062213		2/2/09
H		30. Name and address of person who completed cause of death (Item 23a) (Type, Suresh H. Petel, MD			1.00650
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Leonardtown	, Marylan	d 20650
Registra		2 2009 A. A.	arel		

DHMH 17 Rev 1/2001

		ŀ	For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of l			ene g. No. 2009	04714
	Physicia		Decedent's Name (First, Middle, La  Margaret	Hoshall	Burch			2. Date of Death Month	Day Year	3. Time of Death 4:45P M
Medical   Fxaminer   4a. Facility Name (If not institution, give street and not		ing Cente	enter		4b. City, Town, or Location of Death  Leonardtown		4c. County of Death	ry's		
	Funeral Director		,	Sex 1 □ M 2 <b>X</b> F	Age (In yrs. last birthday, 91  Yrs.	Months Days	If Under 24 Hr Hours Mir		Year) 9. Birth Cou	place (State or Foreign ntry) Maryland
	with the Maryland a or 28a-f show be notified at	I Director	Maryland St. M 10e. Street and Number 22680 Cedar Lane	lary's	10c. City, Town or L		n	10	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 X No ntry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.	eted by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gi	12. Was Deceder Armed Force 1  Yes 2 If Yes, Give Year or Date:	No s: 16a. Dece		Hispanic Origin? ( ean, Mexican, Pue  Specify:	Specify Yes or Norto Rican, etc.)	14. Race - Ameri Black, White,	etc.
12121	iled within Hygiene. ther than " nt, the Me	Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las	College (1-4o	life.	School	Teacher	ame (First, Middle, M.	Board of E	ducation
Maryland	nould be fi d Mental H <b>narked ot</b> matic ever	To Be	Bayard B.	I	loshall		Rosa		Kidd	2.41
ore, Maı	es t and 2 st of Health an f item 27 Is n r other traur		19a. Informant's Name/Relationship  Margaret B. Col.  20a. Method of Disposition  PASBurial 2 □ Cremation 3 I	liflower/I	Daughter 2	21875 Whi	tes Neck	Rd., Bush	City or Town, State, Zip  nwood, MD 2  Oc. Location - City or To	.0618
Baltimore,	permit. Pag Department Important: I any injury o		4 Donation 5 Other (Spec  21. Signature of Funeral Service Life  Danielle Ward	ariel	St. Paul'	2. Name and Addre	ess of Facility B	rinsfield	eonardtown, Funeral Ho ardtown, MD	me, P.A.
8760,	Physician // // // // // // // // // // // // //	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Due to or as a consequence of):							
O. Box 6	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown		n 2 Fetal death 3 t at time of death 5	☐ Ectopic pregnand	су		23d. Date of deliv Month	ery Day Year
rds, P.	quires that en signed b utd be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobat 1 Yes						cco use contribute to the cause of death?	
Vital Records,	an: The law requir tificate has been si or, page 2 should I	e Completed	25. Was case referred to medical	Г		/	26 Place of De	24a. Was an autopsy perform 1 □ Yes 2	ed? prior to co death? No 1 □ Yes	opsy findings available impletion of cause of
Division of Vi	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	ation: To Be	examiner?  1  Yes	ntient 2 ER/Outpatie	of 28c. Inju	28c. Injury at Work? 28d. Describe how injury occurred			(y)	
Divis	tal or Atters as after de al Directo	Certification:	3 Suicide 6 Could not to determined	28e. Place of I	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	the Hospi nin 24 hou the Funer npletely fill	Medical	(Check only 2 Medical Exa	hysician: To the be miner: On the basis and manner	st of my knowledge, dea s of examination and/or in stated.	nvestigation, In my	opinion, death occ	ce, and due to the ca curred at the time, dat	use(s) and manner as te and place, and due t	stated. o the cause(s)
	S S S S S S S S S S S S S S S S S S S	2	29b. Signature and title of certifier	Be	er he	29c. Licens (4)	ov 504		d. Date signed <i>Month</i> ,	Day, Year)
	40		30. Name and address of person who  Leon Berube, M.	D.	<u>P</u>		ville, M	aryland 20	0659	
	Sta Registra		31. Date filed (Month, Day, Year) FEB 2 200		Accorded Characterists	de	-	_		

DHMH 17 Rev 1/2001

Registrar

Madeline

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Physician David Earl Blisard 40 A 30 2009 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 180-34-4819 65 Pennsylvania March 26 1943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygjene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Ex-miner must be notified at MD Dorchester Cambridge 1 XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🛣 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) defense contractor government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Stratton Blisard Jr. Alexina Robinson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Adams 126 Market Square, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State ō 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Salisbury Crematory 2/1/09 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD ture of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherose **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner es Co Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a conseque Examiner Pulmonely desease that initiated events be exec resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the L nding p nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery atten 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 X No page 2 certificate I 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ပ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After al or Attending F after death. I Director: After d in by the funera 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in To the Hospital or within 24 hours at To the Funeral D

Box 68760, P.O.

Baltimore, Maryland 21215-0036

Division or Vital Records,

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50 31. Date filed (Month, Day,

Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Dav. Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MYRA KEMP BISHOP 12:03 PM 31 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11113 Assateague Rd. Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month Day Year) 12/11/1921 9. Birthplace (State or Foreign **Funeral** Great Britain 87 225-60-7518 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No MD Berlin Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or items 23a or uny or other traumatic event, the Medical Express. 11113 Assateague Rd. 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ XNo Specify þ white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Administrative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Kemp Caroline Hughes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 Jonathon's Glen Way, Herndon, VA 20170 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra Carolyn Norris/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 2/2/2009 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signatural Funt ral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** chemine CA Z /Medical Due to (or as a consequence of): Examiner auture of Chanie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) the burial-trar P.O. Box 68760. attending physician for use as the buria Physician/Medical anoveria 20 Canor 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown in Freetoble pain Completed 14 per lipitome-24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 400 24a. Was an certificate 1 □Yes 2 No arthurbs 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H 0066462 Fillel 2-2-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 3 Jeffrey Scheirer 10514 Racetrack Rd., Berlin, MD 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

James George Brandlen  A. Facility Name (of not institute), give a seed and number of Moran Manor Nursing Home  A. Facility Name (of not institute), give a seed and number of Nursing Home  A. Facility Name (of not institute), give a seed and number of Nursing Home  A. Facility Name (of not institute), give a seed and number of Nursing Home  A. Facility Name (of not institute), give a seed and number of Nursing Nursing Home  A. Facility Name (of not institute), give a seed and number of Nursing Nursing Home  A. Facility Name (of not institute), give a seed and number of Nursing Nursin				1- For State of Maryland Department of Health Registrar  Amend Item 8 per Th, 8898, 12722/09 dhb  Certificate of Death	and Mental H	ygiene Reg. No.?	na	01.718
Second Second Continue   Account of Death   Accounty of Death   Allegany							0 Year	3. Time of Death 2:00 A M
277-28-9064   XCM 2   F   78   Yrs   Months   Days   Hours   Min.   05/18/1930   Marry1and   Marry1a	1			Moran Manor Nursing Home Westernport	t			
Top   County   Coun	ı			217-28-9064 X□M 2□F /8 Yrs. Months Days Hours	8. Date of B Min. 05/18/	irth Day, Year) 1930	9. Birthp	place (State or Foreign 1771 and
Provided   Provided		Maryland	tor	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
Provided   Provided		h with the	al Direc					
Provided   Provided	9600	nours after deatlural", or items 2	ğ	1 Never Married 2 Married I			ck, White, e	etc.
18. Mother's Name (First, Middle, Maiden Surname)   Mary Munsie	121	within giene. r than	omplete	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-)  (Give kind of work done during most life. DO NOT use retired)	est of working			lustry
20a. Method of Disposition    Second	p	0 0 0	Be	To moun			ne)	
Physician / Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate ceuses. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	, Mar	and 2 sho ealth and n 27 Is ma	Ė		ber or Rural Route Numi 1 Ave, Bloc	ber, City or Town, omingto	State, Zip n Ave	Code) e 21523
Physician / Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate ceuses. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	imore	Pages 1 ment of H ant; If Iter ury or oth		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)			•	
Physician /Medical Examiner  Physician /Medical Examiner  Sequentially list conditions, if eny, leading to immediate cause (Disease or injury that initiated events resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Balt	permit. Depart Import any Inj		21. Signature of Euneral Service Licensee 22. Name end Address of Facility  Tober 1 House 1 Church St, Wes	ity Boal Fun	eral H	ome,	111
FFEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Year   1   1   1   1   1   1   1   1   1	E	/Medical Examiner	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events  a. Due to (or as a consequence of):  Due to (or as a consequence of):	estive Lu	y Va se	><	Interval Between Onset and Death Lycurs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Ankronson    24a. Was an autiopsy performed? 1   Yes 2   No 3   Probably 4   Ankronson    24b. Were autopsy findings avail prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Ankronson    24b. Were autopsy findings avail prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Ankronson    25c. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA    27c. Magner of Death   Part III. Other significant conditions contribute to the cause of death    25c. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA    27c. Magner of Death   Part III. Other significant conditions contribute to the cause of death    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    29a. Certifier (Check only one)    29a. Certifier (Check only on	.O. Box 68	by the attending packed for use as t	nysician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				
24a. Was an autopsy performed? 1   24b. Were autopsy findings available prior to completion of cause death? 1   25. Was case referred to medical examiner?   25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Magner of Death   27. Magner of Death   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury   28c. Injury   28d. Describe how injury occurred   28d. Describ	ords, F	en signed ould be det	5					h
Column   Check only one   Check	ital Reco	tificate has be tor, page 2 sho	e Complet	25. Was case referred to medical	auto perfo 1 ∐ Yes	psy prmed?	rior to com leath?	pletion of cause of
27. Magner of Death   1	V V	his cer I direct		examiner? 26. Flace			er (Specify)	)
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	he Hospit	in 24 hour he Funera pletely fille		LE Medical Examiner, On the basis of examination and/of investigation, in my opinion, deal	nd place, and due to the ath occurred at the time,	cause(s) and ma date and place, a	nner as sta nd due to t	ited. the cause(s)
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Jo.	with To t	Σ	29b. Signature and title of certifier  29c. License number	1.01	29d. Date signed	(Month, D	ay, Year)
30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)			2	30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)	144	2/2	120	09
State Registrar  FFR - 2 2009  A State Registrar  State Registrar  State Registrar  FFR - 2 2009				JUSUS 141 MD 4 Broadway, Frostb 31. Date filed (Month, Day, Year) 32. Registrar's Signature	urg, M	1) 215	532	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 10C, FH, TCHD, 02/04/09, pha Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Month William James Bledsoe, Sr. 1549 /Medical am ugng 31 2009 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death top tel Memorial at EASTON TALBOT ASTON 5. Social Security Number Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-11-1935 9. Birthplace (State or Foreign Country)
Tn. 7. Age (In yrs. last birthday) **Funeral** Days Hours 217-30-9245 **Director** 73 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Ridgely Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director Md. 1 ☐ Yes 2 No Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11511 Ridgely Road 21660 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1□Yes 2MNo <u>ک</u> Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Caroline County Elementary/Secondary (0-12) College (1-4or 5+) Educator Board of Education 17. Father's Name (First, Middle, Last) ith and Mental F. 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis Bledsoe ပ Mary Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia Janis Bledsoe/Wife 11511 Ridgely Rd., Ridgely, Md. 21660 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Spring Grove Cem. 02-07-09 Denton, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home Signature of Funeral Sa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 426 Dover St., Easton, Maryland21601 Immediate Cause (Final **Physician** 20 MINUTES disease or conditio /Medical resulting in death) Due to (or as a consequence of): **Examiner** Z hours sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last burial-Due to (or as a consequence of) Box 68760, attending physician law requires that the death certificate be Physician/Medical the as IF FEMALE: for use a If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy page certificate 2 🗆 No 1 □Yes 2 No 1 ☐ Yes Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes this Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) 3+VA Idewid AJR 71601 31. Date filed (Month, Day, Year) FEB 0 4 2009 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 04720 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30, 2009 2:30 A M Philip Curtiss Byrne January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairhaven Health Center Sykesville Carroll 8. Date of Birth (Month, Day, Year) 9. Birth (Month, Day, Year) Palestine 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 047-30-8323 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Carrol1 Sykesville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21784 USA 7200 3rd Avenue C-140 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a any injury or other traumatic event, the Medical Examiner must. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) General Manager Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Owen Joseph Byrne Phyllis Torrance ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 3rd Avenue C-140 Sykesville, MD 21784 Ann S. Byrne/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State W. Arundel Crematory 01/31/09 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 21. Signatur of Funeral Service License Going Home Cremation Service P.O. Box 784 Leve Hellotte MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Spontaneous subduct hematorna **Physician** Huys /Medical Due to (or as a consequence of) Examiner Coasulopathy Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe Stroke 20 No Division or Vital filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D34849 30 2009 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) (m) William Tan & Idershur 1645 MID Libert State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 2009 Richard Arnold Butler 26, 4:20 /Medical Jan. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Clavert Memorial Hospital Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Hours Months Days 79 Director 408-36-4779 4/8/1929 TN Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notifled at 1√∑Yes 2 No Calvert Directo MD Lusby the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20657 USA Funeral 12779 Mill Creek Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iten important: or the marked other than "natural", or Iten and Injury or other traumatic event, the Medical Examines one. Armed Folces: 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Carpenter 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Jeff Butler Pearl Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Butler/Son 4320 Linthicum Rd., Dayton, MD 21036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/09 Beltsville, MD Chesapeake Crem. 21. Signature of Funeral Servic Licensee 22. Name and Address of Facility Raymond-Wood F.H., P.A. 00 PO Box 430, Dunkirk, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes Physician /Medical Due to (or as a consequence of) **Examiner** ardionyopa if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician a typer Lindemia Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Hu 5/5 perform certificate I Ceural 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide determined

Division or Vital Records, P.O. Box 68760, after death.

I Director: /

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: Certification: 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier Medical 29b. Signature and title

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D46419

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) and add 30. Name

Hospital Road, Prine Frederich, MD 20678 Letchtord MD A 100 tene 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

2009 Cloures

		State Registrar		•		tificate of l	Death	,	giene	009	04722
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	h	9. Birthi	place (State or Foreign
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filed within 72 hours after death with the Maryland Hygiene.  there than "natural", or items 23a or 28a-f show art, the Medical Exempton in the De nothing at any the Medical Exempton.	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	.S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14.	Race - Americ	
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iten		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other plac	e)	Date	20c. Location	on - City or To	own, State
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		For State of Maryland /	Department of Health and Menta	al Hygiene	2.2
		Registrar	Certificate of Death	Reg. No. 2009 047	23
Physicia		Decedent's Name (First, Middle, Last)	Mo	e of Death nth Day Ye ar	th
/Medic		Everlena	Bolden 1	-28-09 21:31E	$P_{}^{M}$
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
		Southern Maryland Hospital	Clinton	Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Months Days Hours Min. (Mo	e of Birth onth, Day, Year) 7, 10,16 9. Birthplace (State or For Country)	reign
Director	-	212-56-0634   12   92   92   Usual Residence of Decedent		7-1916 Maryland	
yland Iow		10a. State 10b. County 10c. City, Tow	vn or Location	10d. Inside City Lin	mits
Mar a-fsh	향	Maryland Prince George Brand	lywine	1 <b>⊠</b> Yes 2 □	]No
th the		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
ours after death with the Marylan al", or items 23a or 28a-f show		12401 Lusby Lane	20613	USA	
r dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	s or No- etc.) 14. Race - American Indian, Black, White, etc.	
or if	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 □Yes 2 ☑ No Specify:	Specify:	
		3℃ Widowed 4 □ Divorced Year or Dates:	a. Decedent's Usual Occupation	Black 16b. Kind of Business/Industry	
n 72 "nai	lete	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)	FOD. Kind of Business/fildustry	
filed within 72 ho Hygiene. other than "natur ent, I'r Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	Domestic	
filed Hyg other	Be C	17. Father's Name (First, Middle, Last)		Middle, Maiden Surname)	
ld be lenta ked ic ev	To B	Percy M. Tolson	Alverta	Weems	
shou and N mar	_		b. Mailing Address (Street and Number or Rural Route		
ies 1 and 2 should be filed within it of Health and Mental Hygiens it of Health and Mental Hygiens if item 27 is marked other than "filem 27 is marked other than "for other traumatic event, I'm I'm I'm I'm I'm I'm I'm I'm I'm I'm		George Bolden / Son 35	504 Manis Rd, Clinton	Marvland 20735	
ss 1 a of He item		20a. Method of Disposition 20b. Place comparts	of Disposition (Name of Date ery, crematory or other place)	20c. Location - City or Town, State	
permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau		XII Burial 2 II Cremation 3 II Removal from State	Bethel AME 2/7/09	Brandywine, MD	
rmit. partn porta y Inju		21. Signature of Jureral Service Licensee	22. Name and Address of Facility	20608	
e a E e a		Llux 191	Adams Funeral HomeP	A, Aquasco, Maryland	
		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or respi	ratory arrest, Approximate Interval Between	n
Physician		Immediate Cause (Final disease or condition	11UE VIEART FAILUR	Onset and Death	h
/Medical Examiner		resulting in death)  Due to (or as a consequence	e of):		
Examiner	<u></u>	Sequentially list conditions, b. CARDIOI	nyolatuy		
led isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e or):		
be executed ician and burial-transit	хап	that initiated events c	e of):		
te be executed ysician and e burial-transit	cal E				
leath certificate attending physi		d			
n cert	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
atte for	icia				
g 6 d	ဟြ	1 Tyes 2 No. 4 Pregnant at time of death		Month Day Year	
t the de by the a		in the past 12 months?  1   Yes 2   No 9   Unknown		Month Day Year	
s that the de gned by the	y Physician/Medi	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	5 ☐ Other (specify)	Month Day Year le. Did tobacco use contribute to the cause of death	?
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iaw requires that the case been signed by the 2 should be detached	by	9 Unknowh	5 ☐ Other (specify)in the underlying cause given in Part I. 23	le. Did tobacco use contribute to the cause of death'  1 Yes 2 No 3 Probably 4 Unknows a. Was an 24b. Were autopsy findings availa	own able
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Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death. within 24 hours after death

To the Funeral Director:
completely filled in by the

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

200 Civic Ave. Salisbury, MD 21804 Paulette CRNP vec 31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Amended item Registrar	#9,WCHD,1.30.	09, SLEe	rtificate of	Death	Reg. No	2009	04725
	Physici	an	1. Decedent's Name (First, Middle, La	^ ^	1		2.	Date of Death Month D	av Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, gi	R. Brau	sley	4h City Town o	r Location of Death		c. County of Death	1655 M
- Andrew	Examin	er			enter		5AUS6424		Nicani	c
	Funeral		Social Security Number     6.		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	8	Yrs.			7-25-192	Misso	witi
	yland how		10a. State 10b. County	10c.	City, Town or Lo	cation				0d. Inside City Limits
	Ba-f s	cto	VA Accom	rack C	hinco					1 ∑KYes 2 ☐ No
	with th	Dire	10e. Street and Number	0.1		10f. Zip Code		10g. C	itizen of What Coun	itry?
	ms 23	Funeral Director	4334 Pensior	12. Was Decedent Ever in	U.S. 13.	2333 Was Decedent of P	dispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	14. Race - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Evanting must be notified at once.	by	1 Never Married 2 Married 3 M Widowed 4 Divorced	Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: \900		lf Yes, specify Cub 1 □ Yes 2 ☑ No		an, etc.)	Specify: White,	ite
5-0	72 hc "natur	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup	oation during most of working d)	16b. l	Kind of Business/Inc	dustry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		eteoral		11	S Mai	11/
d 2	e filed all Hygin other vent, Il	Be Co	17. Father's Name (First, Middle, Las	t)	1 116	- 101010	18. Mother's Name (F	irst, Middle, Maide	n Surname)	7
/lar	uld be Menta arked atic ev	To B	Edward B	rawley			Gladys	Sm	ith	
Maryland	2 shoun and M		19a. Informant's Name/Relationship		19b. Mailii	ng Address (Street	and Number or Rural F			,
	1 and Health em 27 ither t		10athie Derri	ckson, Dayhter	501 D. Place of Dispo	a WT (	10at Lanz		Location - City or To	VA 23336
Baltimore,	Pages nent of int: If Its iry or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	cemetery, crei	natory or other pla	ce)			- N A
altii	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Lice	10	ren woo	2. Name and Addre		Chin	rincotea	90E, VIA
ä	Depar Impo any ir		amanda c	- Bottos	18	alyer Fu	neral Homz	Inc. 632	7 Church	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de , one cause on each line.	eath. Do not en	ter the mode of dyi	ng, such as cardiac or r	espiratory arrest,	4	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Conjest		eart +	ailure			1 Week
Υ'	Examiner			Due to (or at a cons	1 /	onic r	enal fail	W-P		
	B ≠	ner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons		·	CHICK Y ACT	w C		
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Comaru		ry dise	aie			
60,	rtificate be executed ng physician and as the burial-transit		Tooding in doutin Last	Due to (or as a con≰	equence or):	1				
68760,	ifficate g phys as the	Medical		_ d						
.O. Box	death ce e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred  1  Live birth 2 Fregnant at time of 1 Unknown	etal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		23d. Date of delive Month	ery Day Year
S, G,	The law requires that the do ate has been signed by the bage 2 should be detached	by Pt	Part II. Other significant conditions	contributing to death but not r	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
ord	equire sen si	ted l	diabetes melli	tus				1 ☐ Yes 2	2 No 3 Prob	uably Unknown
3ec	8 S	Completed	iron deticience	ganemia				24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
a	n: The ficate rr, pag		hypertension					performed? 1 □ Yes 2 2 N	death? lo 1 🗆 Yes	2 🗆 No
₹	ysicia s certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 200 No	Hospital: Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	26. Place of Death (0		6 ☐ Other (Specify	iv)
n 0	Attending Physician: r death. ector: After this certifica by the funeral director, p	n:T	27. Manner of Death  ↑ Natural 5 Pending	28a. Date of Injury (Month, Day, Year	28b. Time o			d. Describe how inju		,,
Sio	tendii leath. tor: A the fu	catic	2 Accident investigation	on he		M 1 □	]Yes 2□No			
Division of Vital Records,	l or At after o Direct	Certification: To	4 Homicide determined		t home, farm, str e <i>cify)</i>	reet, factory, office	28f	Location (Street a City or Town, Stai	and Number or Rura te)	l Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C		Physician: To the best of my laminer: On the basis of examand manner stated.						
	To the within 2 To the Complete	Me	29b. Signature and title of certifier		-	29c. Licens		l l	ate signed (Month,	
	HV.		· Chull				21808	1	129/09	
	U DI		30. Name and address of person who	completed cause of death (I	rem 23a) (Type,	Print) Regional	) 30813   Medical (	enter Sa	lisbury m	Ø
	Sta		31. Date filed (Month, Day, Year)	SZ. Hegistiai s Oig	gnature		-9-1			
	Registr	al	JAN 20	9660	6	1				

DHMH 17 Rev 1/2001

**O**RIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMENDED #5 PER FH 2/10 Certificate of Death CCHD KN Reg. No. 2 Pecedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Feburaru 2009 2935 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital at Easton Talbot Memorial Easton 5. So**2**al Feculi (6 N 9 66 e 3 5 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. Country, Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiant must be notified at any injury or other traumatic event, the Medical Evantiant must be notified at any injury or other traumatic event, the Medical Evantiant out to be notified at any once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PROLINE Funeral Director Street and Number 10f. Zip Code 10g. Citizen of What Country? 10e. 12. Was Decedent Ever in U.S. Armed Forces?

1 Dres 2 No 1943 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 ☑No Specify If Yes, Give Year or Dates: Specify: WHITE Completed by 3 ₩idowed 4 Divorced 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Maryland Be KAYMOND G BENNETT SR ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREG BENNETT 301 Eagle Fallon, 12 62269-1930 Kidge more, 20a. Method of Disposition 20b. Place of Disposition (drame of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 's Cem HURLOCK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat re of Fineral Service Licensee SBURG MO 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Diseas Obstructive hronic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Ses 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 10 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division Hospital or Attending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 (Q

State Registrar 31. Date filed (Month, Day,

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

219 S. WASHINGTON ST.

Raymond

Beinnett

ELYSLON' WU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 2009 Ba Charlene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex medical center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 🔯 F 10 217-74-3543 MARYLAND Director -13-6 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy liqury or other traumatic event, the Medical Examinat must be ricitled at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1⊠Yes 2 No Director ()A EASLON ARULAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number STREE 21601 633 LOMAX Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐Yes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use, retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE DomEslic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FitchEll BARKIEU LENA ပ GEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or own, State, Zip Code) 19a. Informant's ame/Relationship (Type. Print) -Daughter 106 ALCUA MEAdOW DR. EASTON, MARYLAND POPER 21601 20c. Logation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HEBRON, MARYLAND eiwah! 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hladys FUNERA SAL MO HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 96 4040 CEVI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending humanian and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2 ☐No 9 ☐ Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this

filled in by the funeral d 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 MNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MU

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1- State of Maryland / Departme Registrar Amend Items 23aPt1,25,27,28a-f Certifica	nt of Health and per me, g888, ate of Death	Mental Hygic 02/24/09df Reg	ene nb 1. No. 2009 01.72
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Barbara Bennett		2. Date of Death Month	Pay Year 2225PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. Cit  VENINSWA REGIONAL MEDICAL Center	ty, Town, or Location of Deat	sbury	4c. County of Death, Wilcomico
	Funeral Director		5. Social Security Number 221-20-5163   6. Sex   7. Age (In yrs. last birthday) on the following of the security Number 74   7. Age (In yrs. last birthday) on the following forms of the following forms of the following following forms of the following following forms of the following following forms of the following following forms of the following following forms of the following following forms of the following following following forms of the following following following forms of the following fol	der 1 Year   If Under 24 Hrs is Days Hours Min.		9. Birthplace (State or Foreign Country) Laurel, Delaware
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryie I-f sho	tor	DE Sussex Laurel			1 X Yes 2 □ No
	or 28a	Director	10e. Street and Number 10f. 2	Zip Code	10g	g. Citizen of What Country?
	eath w	Funeral	10096 Locust Street  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	19956	Pagifu Vos or No	USA  14. Race - American Indian.
Mountain State Occur	Ite, INIAL VIALID ATA 13-0030  I and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating must be motified at	þ	1 □ Never Married 2 □ Married   1 □ Yes 2 □ ANO	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2 Monary Specify:	to Rican, etc.)	Black, White, etc.  Specify: White
<u> </u>	n 72 hc "natu	letec	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of V	sual Occupation work done during most of wor use retired)	rking 16	Sb. Kind of Business/Industry
2	A 1 A within giene.	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ria Manager		Food
3	larylaring 212.	Be	17. Father's Name (First, Middle, Last) Ermal Hitchens		me (First, Middle, Ma.	iden Surname)
	Taryia 2 should and Mer is marke aumatic	မ			illowby	City or Town, State, Zip Code)
2	E, Ma 1 and 2 s Health ar em 27 is other trau			Street Bethel		
9	m 0 1-		20a. Method of Disposition  20b. Place of Disposition (Note that the late of Dispositi	lame of r other place)	Date 20	c. Location - City or Town, State
<u>;</u>	DallIIIII  permit. Page Department Important: It any Injury o		21. Signature of Funeral Service Licensee 22. Name	and Address of Facility		aurel, Delaware 700 West St.
à	Der in De		Holly Short-Hannigan Hanni	gan,Short,Dis	haroon F.H	H. Laurel, De. 19956
	Physician		23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mishock, or hear vailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ode of dying, such as cardia	c or respiratory arrest	Approximate Interval Between Onset and Death
70	/Medical Examiner	r.	Due to (or as a consequence of):	eal Tr	and and	W.M.
DIANO	cuted nd ransit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c.	Mlyn	JED BY MEDICAL EXAM	WEH
4 J	ate be executed hysician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):  d.	CERTIFICATION APPRO		
(	ertifica ling ph e as th	Medi	IF FEMALE:			
3 0	the de	Physician/Medical	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	c pregnancy (specify)		23d. Date of delivery Month Day Year
PARY -	w requires that been signed t should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
13 0	VILAI NECO ilclan: The law r certificate has be ector, page 2 sh	Completed			24a. Was an autopsy performe 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
de y	ysician:	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ I	Other	ath (Check only one)	ce 6 ☐Other (Specify)
	Attending Physician: ar death. ector: After this certifici by the funeral director, p	ation: To	27. Manner of Death  1 Natural  28a. Date of Injury  1 Natural  28b. Time of Formula:  1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	28c. Injury at Work? 1 □ Yes 2 🕱 No		injury occurred Subject fell.
وواواندار	: p#:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)  Home	ory, office	28f. Location (Stree City or Town, S Laure1,	et and Number or Rural Route Number. State) 10096 Locust St. Delaware
	To the Hospital Within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation and manner stated.	on, in my opinion, death occi	urred at the time, date	e and place, and due to the cause(s)
	Noviti Cor	2	Rolla Colto	1005619	7	I. Date signed (Month, Day, Year)
	1181		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  100 6 Com 1 ST Saluday ME  31. Date filed (Month, Day, Year)  FEB 0 3 2009  32. Fegistrar's Signature  Authority D. Apark	> 2184 Rol	DERT A. G	oker Do
	Sta Registr		31. Date filed (Month, Day, Year)  FEB 0 3 2009  32. Segistrar's Signature  S. Spark	1		

Month

Day

1 ☐ Yes 2 ☐ No

9609

Year

**Physician** /Medical

**Physician** 

/Medical

Examiner

10a State

12

Director

Funeral

2

Completed

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ပ

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widdel Evantment be notified at once.

Baltimore, Maryland 21215-0036

Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septic Due to (or as a consequence of): Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1€ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 65902

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day-Year)

Registrar DHMH 17 Flev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Vear **Physician**  $P^M$ February 2009 1307 Lois Ann Barnes 8. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Rising Sun 204 Dodson Drive If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 □ M 2 🗓 F Yrs NOV 18, 1927 Director 81 127-18-4566 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinations to exciting a 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ¥Yes 2 ☐ No Director Cecil Rising Sun Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 204 Dodson Drive 21911 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify: ģ 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John LaRouche Lillian O'Shea ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 190 Hostetter Lane, Conowingo, MD Joyce Barnes/Daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 9 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 12009 West Chester, PA 21. Signature of Funeral Service Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last ue to (or as a consequence of Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 98) IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 I IInknown 9 ☐ Unknowr cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 4 Unknown 2 No 3 Probably 1 ☐ Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of . Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation	5 Other (5			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dorothy Jean Cox 1/30/2009 9:35 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🔀 F 578-58-6693 12/16/1943 Washington D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Boundary Ave. 21613 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Journeyman Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Edgar Sier Kathleen Engelbrecht 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Marie Murphy / Personal Representative 2040 Dailsville Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mid Shore Cremation Center 2/3/2009 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any Injury or other traumatic event, the <u>Medical</u>

Director

Completed by Funeral

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-trans been signed be should be deta certificate has birector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	omplications that caused the d nly one cause on each line.	eath. Do not enter the mode of dying, such as	ral Home, P.A., 308 H. cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. <u>metasta</u> Due to (or as a cons	atic lung car	ncer	24625
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	sequence of):		
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):		
	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
1	s contributing to death but not	resulting in the underlying cause given in Part I	23e. Did tobacc	to use contribute to the cause of death?
119001013/	) FI, G1 600 F	<u>-</u>		2 No 3 Probably 4 Unknown
	),, (1,000)		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	, <b>(</b> , 000)		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	Hospital:	26. Place	24a. Was an autopsy performed 1 Yes 2 1	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigations of the second of	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	26. Place 2 □ ER/Outpatient 3 □ DOA Other: 4 12 Nt	24a. Was an autopsy performed 1 Yes 2 2 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4	24b. Were autopsy findings available prior to completion of cause of death? No 1   Yes 2   No
25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	26. Place 2 ER/Outpatient 3 DOA Other: 4 No. 2 SBb. Time of linjury at Work?	24a. Was an autopsy performed 1 Yes 2 A e of Death Check onl one ursing Home 5 Residence 28d. Describe how in	24b. Were autopsy findings available prior to completion of cause of death?  No 1   Yes 2   No    6   Other (Specify)  njury occurred
25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga 2 Accident 3 Suicide 4 Homicide 6 Could not determine	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year tion of be led 28e. Place of injury - A building, etc. (Sp.	26. Place 2 □ ER/Outpatient 3 □ DOA Other: 4 No. 2 □ SBb. Time of Injury M 1 □ Yes 2 □	24a. Was an autopsy performed 1 Yes 2 2 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4 2 4	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No  2 6 Other (Specify)  Injury occurred  2 and Number or Rural Route Number, tate)

State

Registrar

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Patricia X. Johnson, D. O., 100 Bramble St., Cambridge, MD 21613

31. Date filed (Month, Day, Year)

**FEB 0 4** 

HO059973 2/2/09

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Donald Vincent C001 January 31, 2009 10:00 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2 Kings Drive Taneytown Carroll 8. Date of Birth (Month, Day, Feb 16, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1934 Months Days Hours Min. Mary land **1** M 2□ F 74 211-26-4085 Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d Inside City Limits show a or 28a-f show be notified at 1 ☐ Yes 2 No Frederick Emmitsburg Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Items 23a or? r items 23a c 16627 Old Emmitsburg Road 21727 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. urai", or item Armed Forces? 1 Yes 2 No 1954If Yes, Give Year or Dates: 1958 Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 □ Divorced d other than "natura event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Housekeeping Supervisor other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Joseph Cool Alice Topper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard Cool, nephew 16627 Old Emmitsburg Rd, Emmitsburg, MD 21727 20b. Place of Disposition (Name of South crematory or other place) Carroll Crematory 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of Important: If Ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/02/2009 Winfield, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 21. Sign ture of Funeral Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Physician O months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any being to import of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physiciar IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐ Yes 2☐ No Month 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

as been signed by 2 should be detact as t page certificate funeral director, After this

Certification: To

Be Completed by

Medical

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital the 2 WIL LXIVA

or Attending Physician:

24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Yarlagadda

29d. Date signed (Month, Day, Year) 02/02 12009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yarlagadda MD, 826 Washington Lavanya

Road, Ste 204, Westminster

Registrar

31. Date filed (Month, Day, Year) FEB 03

29b. Signature and title of certifier

32. Registrar's Signature

Dark.

		-	For State Registrar		State o	i Marylan		artmen <i>rtificat</i>			ına Me	ntai Hy	'GIEN Reg. No	00	nna	n I	70
			1. Decedent's Nam	ne (First, Middle, L	ast)						2	. Date of De	ath		Voor	3. Time of	Death
	hysicia /Medic		Marj	orie	Evelyn	Cor	zine					anuar	y 25	y, 20	Year 09	3:05	P.M
	xamin		4a. Facility Name (					,	Town, or L				40	. County o	of Death		
g Mil				rt Count				1			erick			Ca1	vert	(0)	
	neral ector		5. Social Security N 577-16-	7192	Sex 1 □ M 2 🂢 F	7. Age (In yrs. 9		If Under Months		If Under 2 Hours	Min.	Date of Bi Month, Di 12/04	191	3	Count	ace (State try) iingto	_
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in the inverted to the many and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.	If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Mar 3 ☒ Widowed	ried 2 Married	Armed Fo	rces? 2 📉 No ve		if Yes, spec		, Mexican, Specify:	Puerto Ri	fy Yes or No can, etc.)	,		, White, e		
hour 2	atura Cal E	pe		15. Decedent's	l Education	4.00.	16a. Dece	dent's Usua	al Occupat	ion			16b. F	(ind of Bus	siness/Ind	ustry	
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shoul	umat	-	19a. Informant's N	lame/Relationship	(Type. Print)		19b. Maili	n <b>g</b> Address	(Street ar	nd Numbe	r or Rural I	Route Numb	er, City	or Town, S	State, Zip	Code)	
alth a	27 Is		Susan K	. McGrat	h, daugh	ter	2380	Sou	ıthwir	nd Ci	rcle,	Dunk	irk,	MD	2075	54	
es 1 es 1	r oth		20a. Method of Dis	sposition Cremation 3	□ Romovel from	20b. F	Place of Dispo	osition (Nar matory or o	ne of ther place,	)	Dat	е	20c. L	ocation - (	City or To	wn, State	
. Pag tment	Jury o		4 ☐ Donation	5 Other (Spec	cify)	Met	ropoli										
permit. Pages 1 and 2 an	any In		21. Signature of F	uneral Service Lic	ensee	Loan						sch Fu e, Ow					
			23a. Part 1. Enter shock, or he	the disease, or co art lailure. List on	mplications that only one cause on e	aused the deat	h. Do not en	ter the mod	de of dying	, such as	cardiac or	respiratory a	arrest,			Approximat Interval Be	tween
Phys	ician dical		Immediate Cause disease or conditi resulting in death)	(Final	a. Ath	erosci		i ca	ndic	vas	cula	r di:	100	20		Onset and	Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	the attending	Physician/N	IF FEMALE:  23b. Was deceder in the past 12  1 ☐ Yes 2  9 ☐ Unknown	2 months?	1 Live	come of pregna birth 2□ Feta nant at time of c lown	Ideath 3	□ Ectopic p □ Other (sp	oregnancy oecify)					23d. Date Mon	e of delive oth	*	Year
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slcia	irecto	o Be	examiner?		Hospital:	Inpatient 2 🗆	SR/Outpatie	nt 3 🗆 D(	Othor			Check only 5 ☐ Res		€ □Otho	r (Canait		
Iling Phy	ector: Affer this certificate has by the funeral director, page 2 s	ion: To	27. Manner of Dea	th 5 ☐ Pending	28a. Date (Mon		28b. Time of Injury		28c. Injury Work?	at	28	d. Describe				7	
or Attendate death	Director: I in by the	Certification:	2 Accident 3 Suicide 4 Homicide	investigati 6 □Could not determine	be 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, st y)			95 2 🗆 1		f. Location ( City or To	(Street a wn, Stat	n <i>d Numb</i> e e)	er or Rurai	Route Nun	nber,
Hospita 24 hours	e Funeral DII etely filled in	Medical C	29a. Certifier (Check only one)	1 Certifying   2 Medical Ex	Physician: To the aminer: On the band man	best of my kno asis of examina ner stated.	owledge, dea ation and/or in	th occurred nvestigation	at the time	e, date an inion, deat	d place, an th occurred	d due to the l at the time	e cause( , date ar	s) and ma id place, a	nner as st nd due to	ated. the cause(s	3)
To the within	to tne Fun completely	Me	29b. Signature and	d title of certifier		^		290	c. License	number				ate signed			
				Eujar	· .C · .	Suro	ma	5	D 5	065	53			1 - 3	0	2009	3
ha)	٨		30. Name and add	lress of person wh	o completed caus	se of death (Item	n 23a) (Type,	Print) (	iyor	7.C	· Si	RAX	JA				
KW C	χ		5 8 5 ) - 31. Date filed (Mo	D.PO	le ch	legistrar's Signa	ture /	Rd.	′ <	De	de	•	m	2_	20	757	
F	Sta Registr		or. Date med (Mo	FFR	_ 3 2000	- /	A A	1.									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** January29 2009 3:02 Bonnie Jean Casey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2918 Green Arbour Court Charles Waldorf If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕱 F 3/27/42 294-36-7295 66 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ? is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Wolfcal Examination until be notified at Director MD Charles Waldorf Y☐Yes 2☐No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with US<u>A</u> 2918 Green Arbour Court 20602 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than 10th Moving Coordinator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chet Stillion Nancy Davis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: if item 27 any injury or other tr. once. 514 Fairmont Dr. Edgewater, MD. Debra Baker/Daughter 21037 20b. Place of Disposition (Name of cemetery crematory or other place Riverdale Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/2/09 Riverdale Park, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses himlely 402 2294 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1, Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 Physician 8 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Vo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mapper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1- Natural 5 Pending investigation 1 ☐ Yes 2 No n 24 hours after death. le Funeral Director: A pletely filled in by the fi 2 ☐ Àccident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ₩ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

FEB 0 2 2009

**Physician** 

/Medical

Director

Funeral

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Be Completed

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Examine

Physician/Medical

Completed

Be

Medical Certification: To

Michael LaPenta, M.D.

FEB 0 2 2009

31. Date filed (Month, Day, Year)

445

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 23, 20ď9ª Richardson 2300 м Jonathan Caless 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days Months Hours t**▼** M 2 □ F England 220-70-9171 anuary 30.1956 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 □Yes 2√√ No Charles Waldorf 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 6709 Manatee Ct. 20603 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Branch Chief CTA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Winfred Caless, Jr. Wilma Louise Hartman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 6709 Manatee Ct. Waldorf, MD Lorie Ann Caless/Wife 20603 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Queen of Peace Cemetery 1/31/09 Mechanicsville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00945 avil (. Ehule AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Fr11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration pneumonia days disease or condition resulting in death) Due to (or as a consequence of): Anoxic Brain Damage weeks Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cardiac arrest weeks Due to (or as a consequence of): coronary artery disease years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2♥ No 3 Probably 4 Unknown 1 ☐ Yes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performad? 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specie House Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) din D 21438 January 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Annapolis,MD

Defense Hwy.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 28, 2009 Eugene Louis /Medical Corbett Sr. 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Solisbury Rehabilitation a Nursing Ctr Salisbur 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Minnésota 95 179-01-1881 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland | Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21804 200 Civic Ave. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: 2 White 3K Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kuhns Jewelers Trophys and Awards 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecile Czapiewski Theodore Corbett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5729 Lawsons Hill Court Alexandria, VA 22310 Michael Corbett/Son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐Removal from State 1 ☐ Burial 2 XCremation Salisbury Crematory 1/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Holloway Funeral Home P.A. Snow Hill Rd. Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Immediate Cause (Final Physician disease or condition resulting in death) ear /Medical Due to (or a consequence of) Examiner year 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MAN Examiner law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page perform 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yo 1 Inpatient 2 ER/Outpatient 3 DOA ပ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: or Attending Injury 1 Natural 5 Pending i after death.

i Director: A
d in by the fu 1 🗌 Yes 2 ∏No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide To the Hospital o within 24 hours aft To the Funeral D 1 💶 🛩 titying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robins, M.D.

State of Maryland / Department of Health and Mental Hygiene 2 () () 9 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1625 M 31 GILL N. CLIPPINGER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hicomico KEGIONAL MEDICAL SALISBURY cente If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 184-14-1295 85 1923 PENNSYLVANIA AUG. 1, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 💢 No Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 706 PINE BRANCH PLACE, APT. H USA 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Ď. 1 □Yes 2 No Specify. WHITE Specify: 3 ₩ Widowed 4 Divorced "natural" WWII Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 CHIEF PETTY OFFICER U.S. NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and 2 should be fil Health and Mental H Im 27 is marked oth ALMA H. SHEARER DAVID D. CLIPPINGER မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Health PAUL L. CLIPPINGER SANDY BRANCH DR., SELBYVILLE, DE 19975 permit. Pages 1 a
Department of He
Important: If iten
eny Injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Kin Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation 2/1/09 CREMATORY OF DELMARVA |DELMAR, DE 21. Signature of Fu 22. Name and Address of Facility HASTINGS FUNERLA HOME, SELBYVILLE, DE Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Met 254 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) The law requires thet the death certificate be executed Exami trar Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the detached 1 ☐Yes 2 ☐ No o 9 Unknown 9 Unknown signed by t d be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s has autopsy perform this certificate 2 No 1 Yes 2 No of Vital 1 ☐ Yes 25. Was case referre o medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 5 Pending investigation death. filled in by the f 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely t and manner stated. 29¢. Date signed (Month, Day, Year) 29b. Signature rtifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3443 WINTERPLACE PE SOTTE TOS SAZISBERY MD ZISCH MITCHE BUTELMAN, PO 31. Date filed (Month, Day, Year) State Registrar

09-00813 Avrian Costen Please Type or State of Waryland / Department of Health and Mental Siene

2009 04740

		For State Certificate of De	eath		Reg. N	lo.	3. Time of Death
Physician/ edical Examine	1.	Decedent's Name (First, Middle.Last)  AVRIAN TUWAYNE COSTEN		Jai	ate of Death onth Da nuary 27, 2	2009	1740 hrs
		a. Facility Name (if not institution, give street and number)  4b. (	City, Town, or Location of Calisbury			4c. County of Wicomico	
Funeral Director	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year If Under Months Days Hours	Min.	Date of Birth (M		9. Birthplace (State or Foreign Country)
ow any	10	Sual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location 10c. MD 10c. City, Town or Location 10c. City 10					10d. Inside City Limits 1 Yes 2 XNo
th the Maryland 23a or 28a-f show notified at once.	10	0e. Street and Number	Of, Zip Code		10g.	Citizen of Wh.	at Country?
÷ * ±	0 1	1 Never Married 2 Married Armed Forces? If Yes,	21851 Decedent of Hispanic Origins specify Cuban, Mexican,  Mexican,  No specify:	in? ( Specify Puerto Rica	y Yes or No- in, etc.)		- American Indian, Black, , etc.
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Baltimore, permit. Pages I al Department of He Important: If the injury or other th		4 Donation 51 Other Sizecify: 21. Signature of Finest: Servin Licensee 22. Nat	me and Address of Facilit	COOPI		MBLES	FUNERAL CO.
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ian:	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient	26.Place of Deat			Residence 6	Other:
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Fo the within To the comple	Mec	29b. Signature and title of certifier	29c. License numb	er			gned (Month, Day, Year) 28, 2009
- 11 71			n Street, Baltimore,	MD 2120	)1		
S Regis	tate	31. Date filed (Month Page Beau) 2 2003 32. Resistrar's Signature	ans				

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i> a	artment of H	ealth and Death		jiene (	) 9	047	141
	P.		Decedent's Name (First, Middle, Last)		<del></del>			2. Date of Dea	th	V	3. Time of	Death
	Physici		Rev. Jose	eph A. Cor	nno11y, 0.	S.F.S.		Februar	y 9, 20	Year 109	1730	P M
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Deat		4c. County	of Death		
		-,-	Annecy Hall			Childs			Cec	i1		
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	Couin	ace (State o	•
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	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 ahow or other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition	IS de pare	20b. Place of Dispo	sition (Name of		Date	20c. Location -			
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Baltimore,	artme ortani Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses	· i	Oblate Co		13,			ds, M	ע	
Ba	permit. Pages 1 and 2 Department of Health a Important: If itsm 27 it sny Injury or other tra once.		1) 21. 9	2:2-	H:	Name and Addressicks Home	for Fun	erals, P	.A. ktop Mi	D 21	921	
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8760,	Physician /Medical Examiner prize pr	dical Examiner	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):  consequence of):							~
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of er: On the basis of and manner stat	f my knowledge, deat examination and/or in ed.	h occurred at the time vestigation, in my of	ne, date and place pinion, death occ	e, and due to the curred at the time, o	ause(s) and ma late and place,	nner as sta and due to	ated. the cause(s	<b>s</b> )
	To th To th	Me	29b. Signature and title of certifier	_		29c. License	e number	1	9d. Date signed	1 (Month, I	Day, Year)	
			1 Sachder	1.S.		Doo	23322		2//	1/0	9	
			30. Name and address of person who core S.S. SACHDEV	npleted cause of de	ath (Item 23a) (Type.	Print) High St	Eel	eton 1	1021	721		
189	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar		0	1				•	
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18th

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year WENDY LIZABETH COOPER 10:55 P /Medical February 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day) **Funeral** 1 M 2 F Months Davs Hours Day. 07 40 202-52-8910 Director Delaware ,1968 Nov. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits pelified Funeral Director 1 ☐ Yes XX No York Delta 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examinan near bear 44 Scott Drive 17314 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ♣☐No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician Publishing of Health and Mental Hygi item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Eachus ၉ Kathryn Houes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey D. Cooper/Husband 44 Scott Drive, Delta, PA of Disposition (Name of Date 17314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State Evans Eagle Crematory 2/16/2009 4 Donation 5 Dother (Specify) Leola, PA 21. Signature of Fun , al Service Leve 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

BREAST CANCER with Metastases

a. BREAST CANCER with Metastases Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 410 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? jo Month Year Day signed by the a 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş been signated b 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate spital or Attending Physician: Ti hours after death. uneral Director; After this certificate ly filled in by the funeral director, pa 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fil Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5643

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DK

State Registrar lendall R

31. Date filed (Month, Day,

duscutor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

roule

MD

555 W-

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9889 3-2-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8,2009 1849 Maxine Carter February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Th (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ KF 203-28-6034 Aug. 17, 1937 PA Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Economic must be notified at 1⊈Yes 2 No Directo Md. PG Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 4612 Omaha Street 20743 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 21X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Black Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Cafeteria Manager</u> DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel Arnold ဂ္ Naomi Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4612 Omaha Street
Capitol Heights, Md. 20743

20b. Place of Disposition (Name of cemetery, crematory or other place)

2/20/09 Adrienne Hall/daughter 20c. Location - City or Town, State 20a. Method of Disposition 2/20/09 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Mem. Cemetery Suitland, Md. Lincoln 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service License 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Partit. Enter the disease, or complications that sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Physician/Medical Examine law requires that the death certificate be executed neury the burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 11 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☑No : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 2 🗹 No 1 TYe/s 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old Branch Ave. # c-101, Clinton, ND 20735 Berwa, N. M.D. 32. Registrars Signature

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ELEANOR CLUPP /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RECARE HOMEWOOD BALTIMORE 9. Birthplace (State or Foreign Country) MCAIGAN 8. Date of Birth (Month, Day, Year) 9-21-26 Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F Min Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If hear 21s marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified to once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director **CASADENA** 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number D.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WhITE Specify Completed by 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OUSEKEEPER HOTEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NELLE FRANCES ERNEST CLINTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94512Th ST. Pasapana, MO-21122 MATER FRANCES HARDIN, DAG 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2-12-09 HANOVER, MJ. 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service License is of Facility DAUGHERTY FUNERAL HOME 2601 MOUNTAIN RD. MASADENA ZIIZZ of complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, of centreshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Mesmetr Physician /Medical Due to (or as a consequence of): Éxaminer ollow vin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Box 68760, Breem Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown JUNA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas A HAS Hom), 82( N. Sulaw St Soute 304 BALTIMORE MI) 32. Registrar's Signature 31. Date filed (Month, Day,

29b. Signature and title of certifier

MD

29c. License number

D31464

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

2

DIL

			For State Registrar	State of Ma	li yiai ii		rtificate of l			Reg. No.	39	04745
ı	Physicia		1. Decedent's Name (First, Middle, Last)  Nellie K. Crut	tchlev					2. Date of Dea Month February	Day	Year 9	3. Time of Death 9:10p M
	/Medio Examin		4a. Facility Name (If not institution, give s Frederick Memo	street and number)	nita	1	4b. City, Town, or Frede	Location of Death		4c. County		
	Funeral Director		Social Security Number 6. Sex	7. Age		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day December			place (State or Foreign ntry)
	aryland show	٥٢	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederic	k	10c. City	, Town or Lo	cation Middletown				1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M 3a or 28a-f t be notifie	Funeral Director	10e. Street and Number 11 Boilbeau Court				10f. Zip Code 217	69	1	10g. Citizen of V	/hat Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Mudical Eventian route be notified at once.	by	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba I□Yes 2⊠ No		pecify Yes or No- Rican, etc.)		k, White,	can Indian, etc. ite
Maryland 21215-0036	within 72 ho jiene. r than "natur the Medical I	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation co <i>mpleted)</i> College (1-4or 5	+)	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired AMSTRESS	during most of work		16b. Kind of Bu		dustry
land ?	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Edgar Knill					18. Mother's Nam Addi	e (First, Middle, I Le Keefer	Maiden Surnam	е)	
, Mar	and 2 sho salth and I 1 27 Is ma er trauma		19a. Informant's Name/Relationship (Туд Barbara Lee Crutchley			T.	ig Address (Street a				State, Zip	) Code)
Baltimore,	Pages 1: ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	thsburg	sition (Name of natory or other place Crematory	10, 2	ary 009	20c. Location - Smithsbu	ırg, M	Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	2	M014	33   22 Ke	Name and Address eeney & Bas 06 East Chu	ss of Facility ford P.A. F rch Street,	uneral Ho Frederic	me k, Maryla	nd 21	701
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each lin  Due to (or as a	e. 	PD	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
	recuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissas or injury that initiated events resulting in death) Last	Due to (or as a								
68760,	rificate be executed ng physician and as the burial-transit	edical E	d		Consequ	lence or).						
	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of the first 1	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	/		23d. Dat Mo	e of delive	ery Day Year
rds, P	w requires that s been signed b should be deta		Part II. Other significant conditions con	tributing to death bu	t not resu	llting in the ur	nderlying cause give	en in Part I.		bacco use contr es 2 □ No		he-cause of death?
		Completed							24a. Was a autops perform	med?	Vere auto rior to co eath? □Yes	opsy findings available impletion of cause of
	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	- 0 D	ER/Outpatier	t 3 🗆 DOA Othe	26. Place of Deat			/0	
0	ding Phys h. After this funeral dir	n: Tc	27. Mann of Death 1  Natural 5  Pending	28a. Date of Injur (Month, Day	v	28b. Time of Injury		v at	ome 5 Reside 28d. Describe ho			у)
Division of	Atten deat ctor; y the	Certification: To	2 Accident 3 Suicide 4 Homicide  3 Could not be determined	28e. Place of Injubuilding, etc	ry - At ho	me, farm, str	M 1 🗆	Yes 2 □ No	28f. Location (SI City or Town		er or Rura	al Route Number,
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	Medical (	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of ner: On the basis of and manner sta	examinat	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, d	cause(s) and ma late and place, a	nner as s and due to	stated. the cause(s)
	To the within 2 To the Comple	Ž	29b. Signature and title of certifier	M	0		29c. Licenso	o 64624	2	2/10/		
			30. Name and address of person who co Sandeep Sharma M.D.	400 West	Sevent	h Stree	Print) et, Frederic	ck, Marylan	d 21701			
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r'e Signat	uro						

Registrar

onth, Day, Year)

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

DIL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death January 29, 2009 **Physician** Dunbar Joseph Clarence 3:45A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral U S A 65 217-42-0221 December 15,1943 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland St. Mary's Dameron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17339 Three Notch Rd. 20628 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumant. 12 **Aviation Electronics** Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pau1 W. Dunbar Cecelia B. Carroll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Dunbar/Son 36920 Kimberly Ct., Mechanicsville, MD 20659 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Brinsfield\_Echols January 30, 2009 Charlotte Hall 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral Service Licenses Brinsfield-Echols Funeral HOme, P.A. M00817 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 30195 Three Notch Rd, Charlotte Hall, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as \* consequence of) Examiner Stage Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of) burialphysician Physician/Medical Hypo Kension the attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 ☐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation s after dea. 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mu DOG 7814 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUNEY 29449 CHARLOTTE RANCISCA 20622 CHARLOTTE HALL RD MA 31. Date filed (Month, Day, Year) Registrar's Signature State FEB

DHMH 17 Rev 1/2001

Registrar

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 31, Endla Elfriede DeMattia January 2009 10:30a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M 2 🖾 F 84 22, **Director** 525-64-8691 1924 Estonia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. My digal Exprine 1. Ital by putfiled at once. 1 ☐ Yes 2 No Director St. Mary's Mechanics ville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 40455 Beach Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Translater Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be August Murula Anette Sassijaan ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor DeMattia/Son 40455 Beach Drive, Mechanicsville, MD 20659 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 02/03/2009 Charlotte Hall, MD Brinsfield-Echols 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Coronary Event minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease vears Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐Yes 2 INo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗃 Natural 5 Pending investigation n 24 hours after death. te Funeral Director: Aft oletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D06419 1/31/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

James

31. Date filed (Month, Day,

P. Jarboe,

M.D

32. Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

and

Leonardtown, Maryland 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Amended item Registrar #5, per F. Home, 2/4/09, BA WCH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31 Day **Physician** Albert R. Delacez 2009 12:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester 5. Social Security Number 133 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5/31/1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 □ F 80 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County is marked other than "natural", or items 23a or 28a-f shou aumatic event, the theological Examinar must be notified at 1 ☐ Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12537 Deer Point Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □Xio Specify Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) pe mit. Pages 1 and 2 Department of Health a Im. ortant: If item 27 is an, injury or other tra Judith Rutkiewic 12537 Deer Point Circle, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cape Henlopen Crem. | 2/1/2009 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Burbage Funeral Home 108 William St., Berlin, MD 21811 00 / Jula 23a. Part 1. Enter the Alsease, or complications that so sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failure Renil ALUTE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Hypothermia Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dry gangrene on both feet director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a, Was an autopsy Chronic obstructive pulmonary Vital 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: patient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Division of completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person into completed cause of death (Item 23a) (Type, Print) 9733 Healthway BAS Atlantic Feneral Hospital Szymola DO Balin MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FFR 0 3 5000 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 10:43 A Margaret Seese Dean January 29, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett County Memorial Hospital Garrett 0ak1and If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 ☐ M 2X F 88 Director 220-01-9555 Oct. 9, 1920 China Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Garrett **Grantsville** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 891 Dorsey Hotel Road 21536 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Seese Anna Bowman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia D. Umbel, Daughter 14936 Friendsville Rd., Friendsville, MD 21531 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/31/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Memorial Gardens Oakland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. Ducities 21 N. Second St., Oakland, MD Katherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): aspiration **Physician** disease or condition resulting in death) /Medical CVA with dysphagia Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical The law requires that the death certificate the for use as signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2000No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of De-1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: # 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print) DR, Oakland, Ud 21550 32 Registrar's Signature State Registrar

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	Dhyoloi	1	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Ye	3. Time of Death	
150.	Physicia /Medic	_	MARY ETHEL DYE				FEBRUARY	2 2009	4:30AM M	
	Examin	er	4a. Facility Name (If not institution, give street and number)  HOCDICE CENTED OF OHEEN AND	4b. City, Town, or Location of Death  CENTREVILLE			4c. County of Death  QUEEN ANNE S			
- 2	Funeral		HOSPICE CENTER OF QUEEN AND 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)	
121215-0036	Director	Funeral Director	221-32-8496 1□M 2X F	<b>81</b> Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, SEPT • 12	,1927 M	ARYLAND	
	put		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		MARYLAND QUEEN ANNE'S CENTREVILLE							
			10e. Street and Number	OBNITALI	10f. Zip Code		10	g. Citizen of Wha	t Country?	
			348 KIDWELL AVENUE		21617	1		UNITED	STATES	
			11. Marital Status  12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.	
	irs aft	by F	1 ☐ Never Married 2 Married 1 ☐ Yes Mar N 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:	1 ☐ Yes 2 <b>X</b> No Specify:			Specify: WHITE			
	72 hou natura lical E	ted	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup	ation during most of working	100	6b. Kind of Busine	ess/Industry	
	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)  College (1-4or 5-12)  College (1-4or 5-12)	life. D	OO NOT use retired	d)	<i>'</i> 9	HEALTH	CADE	
	should be filed w and Mental Hygiel s marked other th umatic event, th		17. Father's Name (First, Middle, Last)	NOE	COE	18. Mother's Name	(First Middle M		CARE	
and		To Be	THOMAS J. COOK			LOUISE M	•	araon barnamo,		
Baltimore, Maryland		-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						te, Zip Code)	
	and 2 ealth a n 27 ls		LEE LINCOLN DYE/HUSBAND						AND 21617	
	ges 1 t of He If iten or oth		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, crem	-		AKY 6	20c. Location - City		
	it. Pa intmen intant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensper	CHESTERFI					LE, MARYLAND	
Ba	Depa Impo any I		Thomas K. Helfenlein FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617							
Records, P.O. Box 68760,	Physician /Medical Examiner	Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente	er the mode of dyin	ng, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death	
			disease or condition resulting in death)  a. Uon - Hady kn's Cymphoma 7 mos							
			Due to (or as a	consequence of):	2.	M (0)				
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):						
	hysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and idrector, page 2 should be detached for use as the burial-transit		that initiated events							
			Due to (or as a	consequence of):						
			d							
			IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		etal death 3 Ectopic pregnancy			23d. Date of delivery  Month Day Year		
			1 Yes 2 No 4 Pregnant at							
			9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?			
			The second secon			on arranti.			2 No 3 Probably 4 Unknown	
							24a. Was an	24b. Wer	24b. Were autopsy findings available	
							- autopsy performed? 1∐ Yes 2 ☑ No		prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
			25. Was case referred to medical examiner?							
			1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Nother HOSP						OSPICE CENTER	
	Jing F		27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, Day)  2 ☐ Accident investigation		of 28c. Injury at 28d Work?  M 1 ☐ Yes 2 ☐ No		28d. Describe ho	d. Describe how injury occurred		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa		m, street, factory, office 28f.			ocation (Street and Number or Rural Route Number,		
			building, etc. (Specify)  City or Town, State)							
			29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
			29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea					fonth, Day, Year)		
			1 166270 2.2.09						.09	
	(PAS		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
DAVID HALVERSON, M.D. 8221 TEAL DRIVE, SUITE 302, EASTON,  State 31. Date filed (Menth Day, Year)  22. Registrar's Signature							ION, MAR	YLAND 21	601	
1	Sta Registr									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 04:10AM FEBRUARY ØB 2009 Dofflemver Louise Shirlev /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Joseph Medical Center Saint If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🖾 F 214-34-7548 Director Aug 12 1937 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a, State 10b County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Its Medical Examir or must be redified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21047 Funeral 1115 Chatelaine Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clothing Manufacturing Quality Control 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Eldridge Carl Margaret Elizabeth Shoemaker Gavnor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Department of Health Important: If item 27 any injury or other troops Vickie Luther (Daughter) 1115 Chatelaine Dr. Fallston, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Greenlawn Mem. Park Feb. 6, 2009 Williamsport, Maryland 2 Sign ture of Funeral Service License Osborne Funeral Home P.A. 425 S. Conococheague St. 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 prioriths?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown END-STAGE RENAL FAILURE Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of Injury 28a. 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lelery, M.D.

546-4

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DØØ17695

OSLER DRIVE TOWSON, MARYLAND 21204 HELD 32. Resistrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:02 am Marie Jeannette Dominique January 30 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2⊠F Days Hours Director 76 218-65-3475 July 08, 1932 Haiti Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 福 ral", or items 23a or 28a-f si Examinar must by motified Director 1 ☐ Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7620 Maple Avenue 20912 Funeral Haiti 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify: þ Specify. 3 Widowed 4 Divorced "natural" Black Completed other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c ၉ Louis Michel Marie Laurence Xavier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health and Alphonse Dominique - Son 15605 Evesham Place, Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery : 02/07/2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. T. Wlobers 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Bowel /Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Physician/Medical Exam Acute Renal Failure resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached it 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 1 ☐Yes 2 🖾 No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA After this Certification: To in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D62520 January 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria D'Arbela, M.D., 1500 Glen Forest Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 3 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Dav Year **Physician** Clifton W. Daniels January 28, 2009 1:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 198 Halpine Road Apt. #1469 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠** M 2□ F Months 126-34-8026 61 02/14/1947 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 'natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 198 Halpine Road Apt. #1469 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 1967— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1969 1 ☐ Yes 2 X No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed er than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Supervisor Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental 27 is marked or traumatic ev William C. Daniels ည Francita Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 is / Injury or other trau Vivian A. Daniels 1702 Gunwood Place Crofton, Maryland -wife 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 01/31/09 4 Donation 5 Dother (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral Services > MONDEMAN 7211 Lee Hwy. Falls Church, Virignia 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Datocellular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 ☐ Yes 1 Yes ospital or Attending Physician: I hours after death. uneral Director: After this certifica by filled in by the funeral director, pa Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 2 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 □ No 1 TYes 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital \*\*E'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) FER 02 2009

Ruth He, M.D.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Aegistrar's Signature

Lombardi Cancer Center, Georgetown University Hospital, Wash DC

ND035040

amend line 1 per phy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 20b per fd State of Maryland / Department of Health and Mental Hygieney | | | | | | aaco hlth dept state 26/09 dlw Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Janet Lee Ziegler Dudley Year 326 AM **Physician** 2009 (m) 4127 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth Oct 12, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** <sup>Year</sup> 1924 West Virginia Days Hours Min. 1 □ M 🛠 😾 F 84 579-26-2140 Director Usual Residence of Decedent 10d, Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience must be notified at 10a State 1 ☐ Yes 🏋 🕅 No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21409 United States 1714 Winchester Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ⊡Yes 2 XXXIII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White altimore, Maryland 21215-0036 1 □ Yes 2 📉 No Specify: Specify. þ 3 ₩idowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet Musgrove Bosley Mark Victor Ziegler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1714 Winchester Road Annapolis, Maryland 21409 Janet Lee Dudley Blackwood / Daughter Date unk 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2/6/2009 Arlington, Virginia 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Pervice Licens 147 Duke of Gloucester St. Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EXPERITORY Cully /Medical Due to (or as a consequence of): Examiner NEUMO. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner and burial-trar Hospital or Attending Physiclan: The law requires that the death certificate be exect Due to (or as a consequence of): signed by the attending physician I be detached for use as the burian Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Vear Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 No 3 Probably 4 Unknown cate has been si ORSMUCADE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1 🔲 Natural 5 ☐ Pending investigation n 24 hours after death. e Funeral Director; Aft letely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier munny 22, 2009 D2355 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Horapolis 32 Registrar's Signatur PARKWAY puto 31. Date filed (Mc State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of F tificate of			giene 000	04755
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Ţ.	/Medic Examin	- 21	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of De		4c. County of De	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	11. Wallal Glado	12. Was Decedent Ever in U. Armed Forces?	S.   13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? pan, Mexican, Pi	(Specify Yes or No Jerto Rican, etc.)	Black, WI	nerican Indian, hite, etc.
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Maryland 21215-0036	Aenta Aenta rked ric ev	10 E	Andrew Stewart				Jane	Denton		
ary	should have		19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailir	ng Address (Stree	t and Number o	Rural Route Numb	er, City or Town, State	e, Zip Code)
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altimore,	of He		20a. Method of Disposition		lace of Dispo emetery, crei	sition (Name of matory or other pla	ice)	Date	20c. Location - City	or Town, State
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н			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	n. Do not ent	er the mode of dy	ing, such as car	diac or respiratory a	irrest,	Approximate Interval Between
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DHMH 17 Rev 1/2001

Clarence Denton

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Baltimore, MD 21215-0036 pennit Pages land 2 should be filed within 72 Oppartment of Health and Menal Hygiene. Important: If item 27 is marked other than injury or other transmatic eyest, the Medical To Be Comple.	Calvin 1	Dennis		Ed.	na Ki	Her	
MD 21 d 2 should th and Me in 27 is ma mmatic ev	19a. Informant's Name/Relationship	Douglas	19b. Mailing	Address (Street and Number	A A B	nber, City or Town, Sta	nd MD 2182
re, MD 2  s 1 and 2 shou of Health and N  If item 27 is n  rer traumatic	20a. Method of Disposition	20b.		tion (Name of cemetery,	Date	20c. Location - City of	
altimore, mit Pages I a partment of He portant: If it, ury or other t	1 Burial 2 Cremation 4 Donation 5 Other Spec	Nemoval Itom State	crematory or oth	Canadary F	eh 7 2019	12000-14	II. Warylow
Baltin permit. Departim Importa injury o	21. Signature of Funeral Service Lin	censee		ame and Address of Facility	Inthuns	e ward	Funeral Hon
	Væmne	Shuris	31	4 Cove St	Princes	s Anne	Mary Land
Physician /Medical	23a. Part. Enter the disease, or confailure. List only one cause or	each line.			ac or respiratory arr	est, shock, or heart	Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Occlusive Pulmonary T		DIISM			
	Sequentially list conditions,	b. Deep Vein Thrombosis		ktremities			
miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence c	of):				
_ = 5	events resulting in death) Last	Due to (or as a consequence of	of):				
and tra		d	-				
Sici be	IF FEMALE:	23c. If yes, outcome of preg	gnancy			23d. Date of delive	ery
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funieral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bodical Cortification: To Bo Commisted by Physician/Methods	23b. Was decedent pregnant in the past 12 months?	1 Live birth  4 Pregnant at time of de		tal death 3 Ectopic pro	egnancy	Month	Day Year
Box (death or attended for use	1 Yes 2 No Q V Unkno	7	eath 5 Oti	ner (Specify)			
res that the designed by the a signed by the a betached for the above the ab		ns contributing to death but not r	resulting in the u	inderlying cause given in Part I.		obacco use contribute	
S, P puires t an sign and be c					1 Ye		obably 4  Unknown  autopsy findings available
(ecords, The law require are has been signage 2 should be					auto		completion of cause of
tal Rec	)				1 🗸 Yes	2 No 1 🗸	
Vital Rec ysician: The l his certificate l director, page	examiner?	Hospital: Inpatient 2	ER/Outpatient	26.Place of Death (Ch	eck only one) ursing Home 5	Residence 6 Oth	ner:
1 of Villing Physic	27 Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I			how injury occurred	
ion tendin eath. Ior: A the fu	1 V Natural 5 Pendin	g		1Yes 2No			
Division of Vital Records, pital or Attending Physician: The law requir qurs after death.  irial Director: After this certificate has been sfilled in by the funeral director, page 2 should the Contributor.	3 Suicide 6 Could	not be 28e. Place of Injury - At h	nome, farm, stree	et, factory, office building, etc.	28f. Location ( or Town,		Rural Route Number, City
Ospital ospital hours y filled	29a Certifier	1-1					
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the lodding Contiffication	(Check only 1 Certifying Phy one) 2 Medical Exam	sician: To the best of my knowled iner: On the basis of examination a					
To To	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (A	fonth, Day, Year)
	high,	WO		O.C.M.E.		January 31, 20	09
	30. Name and address of person w		*	A Dalking and Add Odd Co.			
1 EB				et, Baltimore, MD 21201			
Stat Registra	E E D II A	2009 32. Registrar's Signat	A. Sad	the			

Eberly Marguente Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Marguerite Olanda Eberly 9:30 A M January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Julia Manor Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 1 1 F 214-09-0543 91 Director 11/15/1917 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinating and MD Washington Hagerstown TXT Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Virginia Avenue 21740 HS Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ģ Specify White Specify: 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Executive Housekeeper Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank (unk) Fratianni Jesse Belle Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and the alth and the and the and the alth and 27 is Barbara A. Bittorf / Niece 1304 Salem Avenue, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/04/2009 Rose Hill Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to use a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): physician s the burial Box 68760. requires that the death certificate be Physician/Medical nding IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a □Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 2 **Z**No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Solversing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 21∰No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 192 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 62-01-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Khalid M. Waseem, MD, 1126 Opal Court, Hagerstown, MD 21740</u>

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
FEB 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rosetta Carter Essex 26 2009 8:20 P January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Huntingtown Calvert 2249 Smokey Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🗗 F 68 Yrs. Maryland Director May 14, 1940 220-38-3575 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "redical Evan" and the notified at 1 □ **%**és 2 □ No Director VA Manassas 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20110 Funeral 8611 Liberty Trail Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∑No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify þ 3 ☑ Widowed 4 ☐ Divorced Black Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7% in and Mental Hygiene. 7 is marked other than "na 2121 College (1-4or 5+) Elementary/Secondary (0-12) High School Guidance Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) land 2 Carlotta Ozella Kent Robert Melvin Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health 820 Manhattan Avenue Apt. 3L, Brooklyn, NY 11222 other t Carnice Essex - Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 【Removal from State **=** 5 Important: I any Injury o 4 ☐ Donation 5 ☐ Other (Specify) 1/27/2009 Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sladys sevel Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each are Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) be executed Exam physician and s the burial-trans Due to (or as a consequence of) 68760 Physician/Medical attending p for use as Box IF FEMALE: If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) o 9 Unknown σ. s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has l e 2 s autopsy page, performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Vital Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Sisters Residence 6 Other (Specify) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred ospital or Attending I Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c completed cause of death (Item 23a) (Type, Print) 30. Name and address of Aos led (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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		-	For State Registrar	State of Ma	arylanu /		icate of L			Reg. No.	2009	04/59
	Physicia	an	1. Decedent's Name (First, Middle, Las			٨			2. Date of De Month	ath Day	Year	3. Time of Death
*	/Medic	al	4a. Facility Name (If not institution, give		Stwood		City Town or	Leagues of Dooth	Fabruary		2009 County of Death	12:20 PM
	Examin	er	alvert Memo		:4-1	40	P	Location of Death		40.	Calvert	-
	Funeral		E Cooled Coough, Number 6 Co		e (In yrs. last b		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		lace (State or Foreign
	Director		543-34-7495	M 24¥F	73	Yrs.	Ontris Days	Hours Will.	May 23			* *
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Location	on				1	0d. Inside City Limits
	Maryl -f sho iled a	tor	Maryland Calvert		Lusby	,						1 □Yes 2 XNo
	n the r 28a notif	irec	10e. Street and Number		Luczi		0f. Zip Code		T	10g. Citiz	en of What Cour	ntry?
	th wit 23a o ust be	Funeral Director	12720 Cordova Cour	t			20657			Unit	ed State	es
	tems tems	nuel	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of Hi es, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No to Rican, etc.)	)- 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1 🗆	Yes 2 No	Specify:			Specify: Wh	ite
21215-0036	2 hour atural cal Ex	ted	15. Decedent's Ed	ucation	16	a. Decedent	's Usual Occup	ation		16b. Kin	d of Business/Inc	dustry
215	thin 7; e. an "n Medi	Completed	(Specify only highest gra	de completed) College (1-4or 5	5+)			furing most of wor )	rking			
21	filed with Hygiene. ther thar int, the N	Con		3	R	egist	ered Nu				tor's Of	fice
Maryland	l be fil ntal H ed otl even	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan		, Maiden S	Surname)	
Z	should be fand Mental Band Mental Bandwarked of umarked of	잍	Walter Hagquist  19a. Informant's Name/Relationship (7)	Type, Print)	19	b. Mailing A	ddress (Street a	Lois He		er. City or	Town State Zin	Code
<u>≅</u>	and 2 sho ealth and n 27 Is ma		Gerald W. Eastwoo					Ct., Lus				
Ţē,	es 1 and 2 of Health f Item 27 I ir other tra		20a. Method of Disposition	•			on (Name of ory or other plac		Date		cation - City or To	own, State
altimore,	and Prince		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Specif</i> y	Hemoval from State  ')				1	2/23/200	)9 Ar	lington,	Virginia
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	see		22. Na	ame and Addres	ss of Facility R	ausch Fi	mera.	l Home,	P.A.
	0.01 = 10.01		Trichart fevre	ardiner /s	the death Do	P.(	O. Box (	500, Lusi	by, MD 2	20657		Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	o not enter ti	ne mode or dylin	y, such as calula	or respiratory a	irrest,		Approximate Interval Between Onset and Death
ĵ	Physician /Medical		disease or condition resulting in death)		a consequence					•		
	Examiner			0	rectic (	,						
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D	a consequence							
	ecute and -trans	cami	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence	o offi						
68760,	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	edical Examiner		Due to (or as	a consequence	e oi).						
687	ificate g phys as the	edic		d								
Box	w requires that the death certifi been signed by the attending should be detached for use as	100	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		th 3∏Eα	topic pregnancy			2	3d. Date of delive	,
	e deal	Physician/N	in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	4□Pregnant a			ther (specify)				Month	Day Year
P.0	hat th d by t		Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the under	rlving cause give	en in Part I	23e Did	tobacco us	se contribute to the	ne cause of death?
Records,	signe d be (	d by					.,				No 3□Prob	
20	> 0 10	lete							24a. Was	an	24b. Were auto	psy findings available
Be	The law cate has b page 2 sl	Completed							auto perf	psy ormed?	prior to co death?	mpletion of cause of
Vital	io rr	Be C	25. Was case referred to medical					26. Place of Dea	1  Yes ath (Check only	2ktNo one)	1 □ Yes	2XNo
> 7	Physician: this certific ral director,	To E	examiner? 1 ☐ Yes 2⊠ No	Hospital: 1 Inpati	ent 2 ER/C	Dutpatient	3□ DOA Oth	4 Li Nursing F	lome 5□ Res	idence 6	□Other (Specif	y)
D C	Ing P		27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28b y Year)	. Time of Injury	28c. Injur Worl		28d. Describe	how injury	occurred	
Division or	ttend death ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be		ury - At home			Yes 2 No	28f Location	(Street and	Number or Rum	al Route Number,
Οį	after after Direction by	Certification:	4 ☐ Homicide determined	building, e	tc. (Specify)	idiii, diiddi,	, radiory, office		City or To	wn, State)	TVUITIDET OF TILITE	ar riodie Namber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	cal C	29a. Certifier  (Check only  2 Medical Example 1	ysician: To the best niner: On the basis of	of my knowled	ge, death or	ccurred at the tir	ne, date and place	e, and due to the	cause(s)	and manner as s	tated.
	the H nin 24 the F nplete	Medical	one)	and manner st	ated.				uned at the time			
	To To Cor	=	29b. Signature and title of certifier	***			29c. Licens			29a. Date	e signed (Month,	
			30. Name and address of person who	completed cause of o	leath (Item 22a	I) (Type Bri-		7594		rebr	very 2,	3009
de	W8		Chan Hepp mb	11	1 1	i) (Type, Prii Road	_	Frederic	K. MT	) 2	20678	
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	-	,		, , ,		0	P1
	Regist	rar	FFK ()	3 2000 > >	P)	1	/					

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of Mary		artment of H rtificate of L			iene eg. No.200	9 04760
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Phyllis	Maxine		Emmert		2. Date of Deat Month Februar		ar 3. Time of Death 10:30 P M
_	Examin		4a. Facility Name (If not institution, give si Julia Manor Health	Care		Hagersto			4c. County of D Washir	ngton
	Funeral Director		5. Social Security Number 220-16-0105 6. Sex 1□  Usual Residence of Decedent	M OFFE	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 30		Birthplace (State or Foreign Country) [aryland
9-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinations to croffled at	d by Funeral Director	1 □ Never Married 2 □ Married 3 🌠 Widowed 4 □ Divorced	2. Was Decedent Ever Armed Forces? 1 _Yes _2 No IfYes, Give Year or Dates:		OWN 10f. Zip Code 21740 Was Decedent of H if Yes, specify Cuba 1 □Yes 2₩ No	Specify:	pecify Yes or No- o Rican, etc.)	Black, W	A. American Indian, Vhite, etc. White
-61212 DL	be filed within 72 h Ital Hygiene. Ital other than "natu event, Ire Medical	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2  17. Father's Name (First, Middle, Last)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired tary	during most of work ()	sing	16b. Kind of Busine  Social Se  Maiden Surname)	ercurity Admin
-	2 should and Mer is marke aumatic	To E	Luther Barnabus St 19a. Informant's Name/Relationship (Type David C. Emmert/Son	ne. Print)		ng Address (Street	and Number or Ru		r, City or Town, Stat	te, Zip Code) 740
baltimore	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to		20a. Method of Disposition  1  ↑  Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	amoval from State	Rest Have	esition (Name of matory or other place or Cemete) 2. Name and Address	ry 2/12,	/2009	<sup>20c.</sup> Location - City Hagerstow n Funeral	m, MD
	ticate be executed  Physician  Medical  Examiner  the brutal-transit	al Examiner	23a. Part1. Enter the disease, or compliants shock, or heart failure. List only on a limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of).		ng, such as cardiac	or respiratory are	ash	Approximate Interval Between Onset and Death
P.O. Box	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	Bc. If yes, outcome of p  1  Live birth 2  4  Pregnant at tim 9  Unknown	Fetal death 3[ e of death 5[	☐ Ectopic pregnanc ☐ Other (specify)  nderlying cause giv				Day Year te to the cause of death?
Ital Records,	The ate h page	e Completed	25. Was case referred to medical				26. Place of Dea	24a. Was a autop: perfor 1 □ Yes	an 24b. Were prior deat 2 1 1	Probably 4 Unknown e autopsy findings available to completion of cause of h? Yes 2 \[ \sum \text{No} \]
>	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	ospital: 1 Inpatient  28a. Date of Injury (Month, Day, Ye)  28e. Place of Injury building, etc. (S		f 28c. Injur Worl M 1 □	er: 4 Nursing H	ome 5 ☐ Resid 28d. Describe h	ence 6 Other (some injury occurred	Specify) or Rural Route Number,
	To the Hospita within 24 hours To the Funera completely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examir  29b. Signature and title of certifier	ician: To the best of mer: On the basis of exa	amination and/or in	th occurred at the tinvestigation, in my o	ppinion, death occu	rred at the time, o	cause(s) and manned date and place, and 29d. Date signed (M	due to the cause(s)
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,		6 00	al c	7  091	1.9
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's		N. I	Hogen	5+- 0	i mi	21740

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2 - 45 AM 01 2009 Frank Levi Fultz, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington County Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 3,1953 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 218-62-8871 1**X** M 2□ F 55 May Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Experiment wast be notified at Maryland Washington County Hagerstown 1 XYes 2 No Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Instural", or items 23a or 28a-i any injury or other traumatic event, the Medical Examinations to constitute the motion and sones. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Virginia Ave. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Taxi Cab Driver Taxi Cab Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Levi Sultz. Sr. GeorgetteGardenour McKinsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Fultz-wife 813 Virginia Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2-3-2009 Greenlawn Cemetery Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Rome 21. Signature of Funeral Service Licenses rettin 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ten Wel Houte Physician Respiratore disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Obstautive almonaly hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 0600 24a. Was an cate has l , page 2 s certificate 1 □Yes 2 ဩNo this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No ၉ 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 2/1/09 66116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 Andarces alines 3H-L STREET 1 Hagers town, 368 MILL

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland, Department of Health and Mental Hygiene 2 1 9

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 1122 JANUARY AM Nancy 2009 Hardin Fani /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 K F Days Director March 6 1961 435-29-1595 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zìp Code 10g. Citizen of What Country? 12029 N. Scottish Ct. Funeral 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "amy injury or other traumatic event, the Mesone. Elementary/Secondary (0-12) College (1-4or 5+) 10 Dog Groomer Grooming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Nancy Carol Carroll Terri Lynn Hardin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fani - Husband 12029 N. Scottish Ct. Hagerstown MD 21740 Richard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Care Colorado 2/2/2009 Aurora, Colorado Science 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signatura f Funeral Service Licens 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TNOFIC BRAIN INJU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER EJPIRATOR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): physician and s the burial-transit S & that initiated events resulting in death) Last Due to (or as a consequence of) 68760 certificate be Physician/Medical use as attending p for use as Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) s been signed by the should be detached o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 5 ENOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an certificate has page 2 autopsy perform LIUGA 2 A No Division of Vital 1 ☐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

12 Yes 2 \[ \] No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending hours after death. 5 ☐ Pending investigation 1 [] Natural 1 ☐ Yes 2 X No 2 Accident Unknown **Unknown**<sup>M</sup> Director: 9 the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hugestown 12029 N. ScottishCH within 24 hours a nome Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 5 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nombo U, 74 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WINEM MAVID MUTAKO ANTIETM ST HMGRSTONN 32. Redistrar's Signature 31. Date filed /Month Day Year) State FEB 0 3 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Figgs, Jr. 30 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Vicamica Kegional Medical ( Salisburg If Under 1 Year | If Under 24 Hrs Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 216-38-7760 6-19-1942 Director 66 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Phydical Exx. that must be in wither a once. Funeral Director 1 ☐ Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Perry Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 M Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl E. Figgs, Sr. Nannie ۵ Sadler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Figgs - Wife 133 Perry Drive, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 2-2-2009 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCVA disease or condition resulting in death) 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the ettending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2 100 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 T Accident 2 No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier movered 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State

			For State	State of Ma	arylan		rtmen			ınd M	- '	giene Reg. No	000	0 (	11.761.
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Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  15. Decedent's Ed  (Specify only highest gra  Elementary/Secondary (0-12)	12. Was Decedent Armed Forces?  1  Yes 20 If Yes, Give Year or Dates:  1  College (1-4or \$ 5+	No	16a. Dece	1 ☐ Yes dent's Usu kind of wo DO NOT us	2 XNo al Occupa rk done o se retired	Specify: ation during most )	of workin	cify Yes or No- Rican, etc.)	16b. Ki	14. Race - Black, No Specify: 1  nd of Busin	White, etc. 31ack	
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8760,	/Medical Examiner  physician and the purial-transit the purial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Acute Due to (or as  C. Chroni Due to (or as  Large	Rena1 a consequ c Ren a consequ	Failu uence of): nal Insuence of):	suffi			rea					
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Division or	or Attending Physician: The after death.  Director: After this certificate hi in by the funeral director, page	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury		28c. Injun Work		2	ne 5 ☐ Resid 8d. Describe I			<i>ъреспу)</i>	
DIVIS	ospital or Attendents after death hours after death uneral Director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, et	tc. (Specify	v)					8f. Location (8 City or Tov	vn, State	.)		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one)  2 ☐ Medical Example of Certifier  29b. Signature and title of certifier	nysician: To the best niner: On the basis of and manner st	of examina	tion and/or in	vestigation	n, in my o	pinion, dea	th occurre	ed at the time,	date and	) and mann d place, and te signed (/	due to the	e cause(s)
)	5		30. Name and address of person who	completed cause of c	leath (Item	23a) (Type,	Print)	D <sub>2</sub>	20274			Janu	ary 2	1, 20	009
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DHMH 17 Rev 1/2001

# Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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-			Montgomery Villa				Montgon If Under 1 Year	ery Villa			lontgom		
Fune Direc			5. Social Security Number 025–07–0259	6. Sex 7. / 1 ☐ M 2 🖾 F	Age (In yrs. last 90	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D				ate or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any Initian or other than "ratural", or items 23a or 28a-f show			1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (Sp		e		tion (Name of atory or other plac	ı					
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The The cate I	and I	္ပြ							perf 1 □ Yes	ormed? 2 XNo	death?	s 2□No	
VII.		Be	25. Was case referred to medical examiner?	Hospital:			3 DOA Oth	26. Place of Deat					
ding Physician: The h. After this certificate h. finaral director name	2	2	1 Yes 2 XNo 27. Manner of Death	28a. Date of I	itient 2 ER	Outpatient b. Time of	3 □ DOA □	4 LA Nursing Ho	ome 5 Res			ecify)	
nding th.		atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Jay, Year)	Injury	Wor	kí? Yes 2 □No	Loc. Docombo	non injur	, 55541.54		
r Atte	6	Certification:	3 Suicide 6 Could no 4 Homicide determine	ot be ned 28e. Place of I building.	njury - At home etc. <i>(Specity)</i>	, farm, stree	et, factory, office		28f. Location	(Street and	d Number or F	Rural Route	Number,
italo I													
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		Medical	29a. Certifier 1 ★ Certifying (Check only one)	g Physician: To the be Examiner: On the basis and manner	of examination	dge, death and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occur	, and due to the red at the time	e cause(s) , date and	) and manner a I place, and du	as stated. le to the cau	ise(s)
To the vithin To the Complete	:	Me	29b. Signature and title of certifier		otatos.		29c. Licens	e number		29d. Dat	te signed (Mor	th, Day, Yea	ar)
6			Vina G	Edup.			D 4	41162		Janı	uary 30	200	9
			30. Name and address of person v	who completed cause o			rint)				<b>7</b>	, 200	
	State	e	Dr. Vinu Ganti, 31. Date filed (Month, Day, Year)					rmantown,	Maryla	ind 20	0874	·	
Reg	jistra		FEB 03 2	009 Gentu	strar's Signature	park	al						
				1		-							

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_	-	Registrar				Ce	rtificate of	Death		Reg. No.	000	0170
ian	1.1		ne (First, Middle,	Last)					2. Date of Dea Month	Day	Year	3. The of Deal
ical	12	Bertina G		give street and nu	umher)		4h City Town	or Location of Death	February		2009 nty of Death	8:00 a
ner	₩a.		Field Point		iniber)		Elkton	or Ecoalisti of Boat		Ced		
	5. 5	Social Security N		S. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year			h	9. Birthpla	ace (State or Fore
		221-18-69	954	1 M 2 F	77	Yrs.	Months Days	Hours Min.	(Month, Day April 2,		Countr	VA
		sual Residence o										
_	10	a. State	10b. County		10c. C	ity, Town or L	ocation				10	ld. Inside City Lim 1 ☐ Yes 2
양		MD	Cecil		E	lkton			-			
Director	10	e. Street and Nu	mber				10f. Zip Code			10g. Citizen o	of What Count	ry?
<u>ra</u>		2375 Old	Field Point				21921			USA	A	- I- II -
Funeral	11.	. Marital Status	ded OF Manda	Armed F		U.S.   13.	If Yes, specify Cut	Hispanic Origin? (S an, Mexican, Puerl	to Rican, etc.)		ace - America lack, White, e	
by F		1 ☐ Never Mari	ried 2 Marrie 4 Divorced	d ILYes If Yes, G Year or D	2. No ive Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spec	cify: Bla	ick
be		0	15. Decedent's		<b>J</b>	16a. Dece	edent's Usual Occu	pation	1	16b. Kind of	Business/Indi	
Completed	_		cify only highest	grade completed)		(Give	e kind of work done DO NOT use retire	during most of world)	rking			,
E		Elementary/Sec	10	College	(1-4or 5+)	Nurs	e's Aide			Medic	al	
Be C	17	7. Father's Name	(First, Middle, La	ast)				18. Mother's Nar	me (First, Middle,	Maiden Surn	ame)	
To B		York Gar	nett					Reather 1	Newell			
-	19		lame/Relationshi	p (Type. Print)		19b. Mail	ing Address (Stree	t and Number or Ri	ural Route Numbe	er, City or Tow	vn, State, Zip	Code)
		Perry V. 0	Garnett			445	Woodstock	Lane, Wilmii	ngton, DE	19808		
	20	Da. Method of Dis		3 □Removal from	1	Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace)	Date	20c. Location	n - City or Tov	vn, State
			5 ☐ Other (Spe		1	Dohamia N	Manor Cemete	mı Fah	ruary 7, 2009	Boh	emia Ma	nor MD
	2	1. Signature of	uneral Service Li	icensee		DUNCHHIA 1	22. Name and Addr	ess of Facility	Auary 1, 2003	1201		
	re	lisease or conditi esulting in death)	on	_a	Man	1 ( I	- 1A ( (					
cal Examiner	if Ca C	sequentially list control any, leading to in ause. Enter Und ause (Disease at at initiated even desulting in death)	onditions, mmediate lerlying r injury ts	b	o (or as a conse	equence of):	ance					
dical Examiner	if can C three re	any, leading to is ause. Enter Und ause. Enter Und ause. (Disease o ant initiated eveniesulting in death)  F FEMALE:  35b. Was decede in the past 1: 1 □ Yes 2: 9 □ Unknow	onditions, mmediate lenying r injury ts Last nt pregnant 2 months?	b	o (or as a conse	equence of): equence of): equence of): equence of): equence of): financy tal death 3 f death 5	□Ectopic pregnan □ Other (specify)	cy				Day Year
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DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

State Registrar DHMH 17 Rev 1/2001

		For 1 State	State of Ma	aryland / Depa		Ith and Me	ntal Hygien	e	01767
		Registrar  1. Decedent's Name (First, Middle, L	actl	Cer	tificate of Dea		Reg. N	2009	
Physici		NANCY MARIE VIA	,			-		ay Year	3. Time of Death 4:/5P M
/Medic		4a. Facility Name (If not institution, g			4b. City, Town, or Loca		D. J. V. 1	c. County of Dea	
<b>-</b> /4		FUTURE CARE-CHES.	APEAKE		ARNOLE	)		ANNE ARU	INDEL
Funeral			Sex 7. Age	(In yrs. last birthday)		ours Min.	. Date of Birth (Month, Day, Yea	r)   C	rthplace (State or Foreign ountry)
Director		216-24-7907 Usual Residence of Decedent		78 Yrs.		ľ	MY 1, 19:	30 MA	RYLAND
Mot.		10a. State 10b. County		10c. City, Town or Loc	ation				10d. Inside City Limits
a-f st	ctor	MARYLAND QUEEN	ANNE 'S		STEV	ENSVILLE			1 ☐ Yes 2 📉 No
or 28	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	ountry?
s 23a		260 GUYTON				666			STATES
item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 📉	11	as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Speci exican, Puerto Ri	fy Yes or No- can, etc.)	<ol> <li>Race - Ame Black, White</li> </ol>	erican Indian, e, etc.
al", or	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		∐Yes 2 <b>X</b> No <i>Sp</i>	ecify:		Specify: WH	ITE
natur. Sical B	eted	15. Decedent's E (Specify only highest g.	Education	16a. Deced	ent's Usual Occupation	a most of working	16b.	Kind of Business	/Industry
han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life. D	O NOT use retired)	j most or working			11.5
Hygie ther t		9 17. Father's Name (First, Middle, Las	**************************************		HOMEMAKER	Mothodo Name /	First, Middle, Maide	OWN B	OME
and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modical Examinar is ust be notified.	To Be	SAMUEL RAYMON			10.		ON AMANDA	,	חיים
s mar umat	-	19a. Informant's Name/Relationship		19b. Mailin	Address (Street and I				
alth a		CHRISTINE CLARK/	DAUGHTER		GUYTON LANE				
i of H		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispos cemetery, crem	ition (Name of atory or other place)	<b>FEBRUA</b>	e 20c.	Location - City or	Town, State
tant: jury		4 ☐ Donation 5 ☐ Other (Spec	ify)		LLE CEMETER	<b>XY</b> 200	9 STE		E, MARYLAND
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examination to ust be notified a <u>once.</u>		21. Signature of Funeral Service Lice	ensee	Y Fi	Name and Address of LLLOWS, HEL	Facility FENBEIN	AND NEWNA	M FUNER	AL HOME, P.A.
		23a. Part1. Enter the disease, or cor	mplications that cause		)6 SHAMROCK			<u>IARYLAND</u>	
		shock, or heart failure. List only Immediate Cause (Final	y one cause on each iin	e.			espiratory arrest,		Approximate Interval Between Onset and Death
ıysician Medical		disease or condition resulting in death)	- u.	ANCED a consequence of):	DEMENTI	A			
kaminer		On the state of th	h						
sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):					-
and I-transit	xamine	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):					
sician	E E		540 (0) 400	a consequence ory.					
attending physician for use as the buria	sician/Medical		d						
endin use	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		F-4			23d. Date of de	livery
he att ed for	sicie	in the past 12 months? 1 ☐ Yes 2 XNo	4 ☐ Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
d by t etach	Phy	9 Unknow		4 - 4 11 - 1 - 1					
signe I be d	by	Part II. Other significant conditions	contributing to death bu	it not resulting in the un	derlying cause given in	Part I.			the cause of death?
on on	Completed				-			2 DXNo 3 □ P	robably 4 Unknown
g eg	Idm			_			24a. Was an autopsy performed?		utopsy findings available completion of cause of
e has be ge 2 sho	0						1 □ Yes 2,23N		3 2 □ No
lificate has be or, page 2 sho		25. Was case referred to medical			26.	Place of Death (		€ □Other (O	
is certificate has be director, page 2 sho	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1  Innatie	nt 2 □ EB/Outpatient	3 DOA Other:	Murcina Home	3 - nesiderice	o ⊟Other (Spe	- 16.1
ter this certificate has be neral director, page 2 sh	To Be	examiner? 1 □ Yes 2 □ No  27. Manner of Death	28a. Date of Injur		JUDOA 4	ursing Home	d. Describe how inju	ary occurred	ecify)
path. pr: After this certificate has be he funeral director, page 2 sh	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Autural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time of	3 DOA Other: 4  28c. Injury at Work?  M 1 Yes	28		ury occurred	ecify)
fter death. irector: After this certificate has be n by the funeral director, page 2 sh	To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury at Work?  M 1 Yes	2 No 28		nd Number or R	
vurs after death. eral Director: After this certificate has be filled in by the funeral director, page 2 sh	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigatic  3 Suicide 6 Could not 4 Homicide	28a. Date of Injunction on Dee dee 28e. Place of Injunction building, etc.	y 28b. Time of Injury  ry - At home, farm, stre (Specify)	28c. Injury at Work? M 1 Yes	28 No 28	d. Describe how inju Location (Street a City or Town, Star	nd Number or Re	ural Route Number,
24 hours after death. Funeral Director: After this certificate has be letely filled in by the funeral director, page 2 sh	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigatic  3 Suicide 6 Could not 1  4 Homicide determined	28a. Date of Injur (Month, Day bed 28e. Place of Injur building, etc.)	y, Year) 28b. Time of Injury  ry - At home, farm, stre. (Specify)  of my knowledge, death examination and/or inv	28c. Injury at Work?  M 1 Yes et, factory, office	2 □ No 281	d. Describe how injute.  Location (Street a City or Town, State of the cause)	ind Number or Rie)	ural Route Number,
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Actural 5 Pending investigation 3 Suicide 6 Could not 1 determined  29a. Certifier (Check only one)  1 Certifying P	28a. Date of Injunction 28a. Date of Injunction 28b. Place of Injunction 2b. Place of In	y, Year)  28b. Time of Injury  ry - At home, farm, stre . (Specify)  of my knowledge, death examination and/or invited.	28c. Injury at Work? M 1 Yes et, factory, office	28/ 2 No 28/ 28/ ate and place, an	d. Describe how injute.  Location (Street a City or Town, State d due to the cause) at the time, date an	nd Number or Ree) s) and manner and place, and due	ural Route Number, s stated. to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Actural 5 Pending investigation 3 Suicide 6 Could not 1 determined  29a. Certifier (Check only one)  1 Certifying P	28a. Date of Injunction 28a. Date of Injunction 28b. Place of Injunction 2b. Place of In	y, Year)  28b. Time of Injury  ry - At home, farm, stre . (Specify)  of my knowledge, death examination and/or invited.	28c. Injury at Work? M 1 Yes et, factory, office	28/ 2 No 28/ 28/ ate and place, an	d. Describe how injute.  Location (Street a City or Town, State d due to the cause) at the time, date an	nd Number or Ree) s) and manner and place, and due	ural Route Number, s stated. e to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Actural 5 Pending investigation 3 Suicide 6 Could not 1 determined  29a. Certifier (Check only one)  1 Certifying P	28a. Date of Injunction 28a. Date of Injunction 28b. Place of Injunction 2b. Place of In	y, Year)  28b. Time of Injury  ry - At home, farm, stre . (Specify)  of my knowledge, death examination and/or invited.	28c. Injury at Work? M 1 Yes et, factory, office	28/ 2 No 28/ 28/ ate and place, an	d. Describe how injute.  Location (Street a City or Town, State d due to the cause) at the time, date an	nd Number or Ree) s) and manner and place, and due	ural Route Number, s stated. e to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Medical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Actural 5 Pending investigation 3 Suicide 6 Could not 1 determined  29a. Certifier (Check only one)  1 Certifying P	28a. Date of Injunction 28a. Date of Injunction 28b. Place of Injunction 2b. Place of In	y, Year)  28b. Time of Injury  ry - At home, farm, stre . (Specify)  of my knowledge, death examination and/or invited.	28c. Injury at Work? M 1 Yes et, factory, office	28/ 2 No 28/ 28/ ate and place, an	d. Describe how injute.  Location (Street a City or Town, State d due to the cause) at the time, date an	nd Number or Ree) s) and manner and place, and due	ural Route Number,

parked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NE HOUL 0930 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Skyway Manor Assisted Living Annapolis . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Min. 1 □ M 2 Ø F Months Days Hours Yrs Oct.10, 1929 Virginia 230-34-0027 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 XXNo Maryland | Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 United States 719 Maiden Choice Lane Apt# BR621 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 The No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2XXNo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bryant Johnson Myrtle Nichols 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane Apt#BR621 Catonsville,MD 21218 Eugene E. Gilhooly 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 1/24/2009 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a cons ence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) SKY WAY MHUXR 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
Accident 5 ☐ Pending investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Exami attending physician and for use as the burial-trar Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Be Completed by

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show

"natural" er than "natur

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any lijury or other traumatic event, Item 18 and pines.

**Physician** /Medical

Examiner

Director

Funeral

Completed by

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

the Registrar

Medical Certification: To

31. Date filed (Month, Day, State

3 Suicide

29a, Certifier

4 Homicide

W

29c. License number

ENSE MIGHWAY

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

pleted cause of death (Item 23a) (Type, Pr

N

and manner sta-

Year!

29b. Signature and title of cerlifie

6 ☐ Could not be

determined

JAN 26 2009

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of Mary	yland		rtmen					Reg. No. Z U	09	04769
	Physicia		1. Decedent's Name (First, Middle, Last)	Bonnie	Lee	Geyer					2. Date of Dea	Day / 2	Year 009	3. Time of Death  06:20PM
7	/Medic Examin	96.0	4a. Facility Name (If not institution, give s Golden Living C				4b. City,		Location o			4c. County	of Death Vashir	ngton
***	Funeral Director		5. Social Security Number 6. Sex 199-32-1509		n yrs. Ia 65	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da) March 1	y, Year)	Cour	olace (State or Foreign otry) onsylvania
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mandil Hygiene. Important: If them 27 is marked other than "naturall" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Washing  10e. Street and Number  55 East Washi	gton		Town or Lo	10f. Zip	Code 217					What Cour	
0000	tours after dea ural", or items I Examiner m	by	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S		1 ☐ Yes	2 <b>∏</b> No	Specify:		cify Yes or No Rican, etc.)	Specif	VV1.	etc. nite
-61717	ed within 72 h giene. er than "natu ;, the Medi-ai	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5+)		16a. Deced (Give life. I	kind of wo	rk done a	luring mos ) er	st of workir		16b. Kind of B	me	dustry
ryiand	should be file nd Mental Hy marked oth matic event	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  Bill Mills  19a. Informant's Name/Relationship ( <i>Ty</i>	rpe. Print)		19b. Mailir	ng Address	(Street a	T	helma	a Mills	Maiden Surnar er, City or Town,		o Code)
e, Ma	1 and 2 s Health ar tem 27 ls other trau	8	Randy T. Geyer  20a. Method of Disposition	(Son)	20b. Pla		rake	Crt	. Hav	re De	e Grace	e, Maryl	and 2	21078
Daltillor	ermit. Pages bepartment of mportant: If II ny Injury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	ee	Smi	thsbur	g Cr	e <b>mat</b> o nd Addres	ory   ss of Facili	ty J	2009 .L. Dav	ris Fune	ral E	
0	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the ne cause on each line.	<i>MO 1</i> 4 e death.	. Do not ent	er the mod	le of dyin		cardiac o		rrest,		Approximate Interval Between Onset and Death
09/00,	/Medical Examiner  uysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to minieurale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	consequence of the consequence o	ence of):  * f x 1  whose of):  * d x 1			5					
O. Box o	w requires that the death certifics been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 [ 4 □ Pregnant at tim 9 □ Unknown	Fetal	death 3	⊒Ectopic p ∃ Other (s		,				ate of delive	ery Day Year
cords, r	quires that in signed build be deta	þ	Part II. Other significant conditions co	ntributing to death but r	not resu	Iting in the u	nderlying (	ause give	en in Part	1.		obacco use con Yes 2 ☐ No	tribute to t 3  Prol	he cause of death?
tai Keco	The law ate has b page 2 sl	Completed									1□ Yes	psy prmed? 2 No	Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 ☐ No
Or VIE	<u>&gt; .∞</u> o	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital: 1  Inpatient	2 🗆 🛭	ER/Outpatier			er: 4 🗆 🙀		me 5□Resi	one) dence 6 □Ot	her (Speci	fy)
sion o	ding After fune		27. Manner of Death  1	28a. Date of Injury (Month, Day Y		28b. Time o Injury	М		yat ° k? Yes 2□	]No		how injury occu		
Š	ital or Attenins after death ral Director:	Certification:	4 ☐ Homicide determined	28e. Place of injury building, etc. (	(Specify	"					City or To	wn, State)		al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Exam	rsiclan: To the best of r iner: On the basis of ex and manner state	xaminat		rvestigation	n, in my c	pinion, de			, date and place	, and due t	to the cause(s)
	To To	2	29b. Signature and title of certifier	mhil			7	) (/	e number	35	6	29d. Date sign	a (Month,	Day, Year)
	5		30. Name and address of person who c	ompleted cause of deat	th (Item	23a) (Type,	Print)	11	26	12.5	tord	u ~	10	21742
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	82 Registrar's	s Signal	ture	1		(m) 4.	0	ı	1	~	•

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			1 - For State Registrar	State of Maryla		artment of H			iene 009	04770
Г	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	
	/Medic		Juanita Lou Green					February		
1	Examin	er	4a. Facility Name (If not institution, give s	•		4b. City, Town, or		eath	4c. County of De	
			24702 Walter Ave 5. Social Security Number 6. Sex		s. last birthday)	Cascac		Hrs. 8. Date of Birth	Washingt	O II irthplace (State or Foreign
	Funeral Director			M 2∏F	79 Yrs.	Months Days		Min. (Month, Day, March 8,	Year) C	shington DC
			Usual Residence of Decedent		13	l		paren o,	1)2) Wa	Shington Do
	yland		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	a-f s	ctor	MD Washingto	on	Casc	ade				1 ☐ Yes 2 X No
	or 28	)ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	23a	ral	14263 Roosevelt	Ave.		21719	9		US	
	r dez	ne		2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Arr Black, Wh	
36	s afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2🏋 No	Specify:		Specify:	White
8	72 hours after death with the Maryland Insturet, or items 23a or 28s-f show disal Evaninet must be collised at	edt	15. Decedent's Educ		16a Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry
15	n "na	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of	working	roo. Italy of Education	amoustry
212	d with piene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	homen	naker			own ho	me
פַ	e files of he vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, M	faiden Sumame)	
/lai	uld b Menta	ToE	Jacob Kinnamont				Leon P	ritchard		
Maryland 21215-0036	2 sho and and is me		19a. Informant's Name/Relationship (Type	pe, Print)				r Rural Route Number,		Zip Code)
≥,	and ealth m 27 her tr		Susan D. Oakes			Walnut A		lascade, MD		
Baltimore,	t of H to f H ite		20a. Method of Disposition  **DBurial 2	emoval from State	cemetery, cre	osition (Name of matory or other place	:ө)	Date	20c. Location - City of	r Town, State
Ë	tmen tant:		' 4 □ Donation 5 □ Other (Specify)					ruary 12,	2009 Pu	rcellville, V
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28a-f show amount injury or other traumatic event, the Medical Evaluation matter relified at 900s.		21. Signature of Funeral Service License	bridy		2. Name and Addres		Grove-Bo Waynesbo		neral Home, I 7268
	Physician /Medical Examiner	j.	23a. Patr I. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or a. a cons	entu- equence of):	ter the mode of dyin	rt (	erlune discorrespiratory arre	ist,	Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physicien and of for use as the burial-transit	dedical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		-				
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	<u>'</u>		23d. Date of di Month	elivery Day Year
Vital Records, P.	tha de	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	inderlying cause giv	en in Part I.			to the cause of death?  Probably 4. Hunkhown
eco	The law requires ite has been sign age 2 should be	ompieted	Inchoten 1	rellite:				24a. Was ar		autopsy findings available o completion of cause of
<u> </u>		Con	7 3					perform	ned? death?	
/ita	ystcian: is certific director,	Be (	25. Was case referred to medical examiner?				26. Place of	Death (Check only on	9)	
of V	> 00	2	1 ☐ Yes 2 ☐ No		☐ ER/Outpatie		er: 4 🗌 Nursin	ng Home 5 Heside	nce 6 □Other (Sp	ecify)
ono	ding After fune	tion:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	or Atten after deal Directors in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st			28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
	Hospitel (     24 hours al     Funerel D     letely filled i	edicai (	29a. Certifier (Check only one)	iician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deal nation and/or in	th occurred at the tin exestigation, in my o	ne, date and pi pinion, death o	lace, and due to the ca occurred at the time, da	use(s) and manner attended and place, and du	as stated. ue to the cause(s)
	To the h within 2- To the I complet	Me	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed (Mor	nth, Day, Year)
			Indered	1/1/	h.	1) 2	7762	3 (	Chrum	C 7.414
			30. Name and address of person who co	mpleted cause o death (It	em 23a) (Type,	Print)		0	1	, 2001
			frederic H	CASS III	my	UIIVm	educh	Connuc	(2d 11e	igen frunk
	Sta Regist		31. Date filed (Month, Day, Year) FFR 1 7 200	32 Registrar's Sig	nature	arked		*		27742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2009 2:29 P M January HAEL TERESITA ROSOPA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 9. Birthplace (State or Foreign Country)
Philippines 8. Date of Birth (Month, Day, Year)
Oct. 12,1930 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Months 1 □ M 2 🖼 F 78 none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ☐Yes 2x No Hagerstown Maryland | Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 Philippines 18323 Berwick Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: Asian 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) midwife Philippines government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paula NMN Presado Rosopa, Sr. Ranulfo NMN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18323 Berwick Terrace, Hagerstown, Maryland Mervin Hael - son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/3/09 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses 415 East Wilson Blvd., Hagerstown, Maryland 21740 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or corr, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): HOURS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises) Due to (or as a consequence of): Anterior Rectal HOURS

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division of Vital Records, P.O. Box 68760, s been signed by the should be detached certificate has briector, page 2 s After thi funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ral", or items 23a or 28a-f shov Examirer must be nutified at

Director

Funeral

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Completed

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Maryland

the !

**Physician** 

resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown  Part II. Other significant conditions on		pic pregnancy or (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying Abscen, Sepsi's,	Aspiration Part I.		to use contribute to the cause of death?  2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical		26. Place of Deat	h (Check only one)	
	Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □	☐ DOA Other: 4 ☐ Nursing Ho	ome 5 🗆 Residence	6 ☐ Other (Specify)
27. Manner   Peath	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
27. Manner   eath   1 - atural   5   Pending   2   Accident   3   Suicide   4   Homicide   determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a, Certifier 1 F Certifying Phy	ysician: To the best of my knowledge, death occu inner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place ation, in my opinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of gertifier	MD	29c. License number	29d.	Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

3H-3

Street, Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 04

400

32. Registrar's Signature

W.

Months

10c. City, Town or Location

Certificate of Death

1 - State Registrar 1. Decedent's Name (First, Middle, Last)

Iva Jean Heltibridle

Rea. No 2. Date of Death

3. Time of Death

4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

Feburary Day 1, 2009 4:45 A M

**Funeral** Director

28a-f shov

23a or death with

or items

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinations.

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-trai

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signed by

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certificate

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After this funeral of

d in by the f

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

SH-L

Physician/Medical

<u></u>

Completed

Be

Certification: To

Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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traumatic event, the Medical Exercitive nust be notified at

Maryland

Ravenwood Lutheran Village 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hagerstown

4c. County of Death Washington

10g, Citizen of What Country?

1926

219-20-2801

1 □ M 2 🔀 F

8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Days Hours AUG.

Birthplace (State or Foreign Country)

Usual Residence of Decedent 10a. State 10b. County

10d. Inside City Limits 1XYes 2 No

MARYLAND 10e. Street and Number

WASHINGTON

HAGERSTOWN 10f. Zip Code

MARYLAND

1183 LUTHER DRIVE

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No

21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A. 14. Race - American Indian. Black, White, etc.

1 Never Married 2 Married 3 Midowed 4 Divorced

1 ☐Yes 2 X If Yes, Give Year or Dates:

16a. Decedent's Usual Occupation

1 ☐ Yes 2 🗵 No

WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

(Give kind of work done during most of working life. DO NOT use retired)

Specify

16b. Kind of Business/Industry

8 17. Father's Name (First, Middle, Last) CLERK JEWELRY STORE 18. Mother's Name (First, Middle, Maiden Surname)

WILLIAM CLARENCE REEDER

IOLA GERTRUDE POFFENBERGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2/04/2009

19a. Informant's Name/Relationship (Type. Print) ELDON JONES/NEPHEW

20b. Place of Disposition (Name of cemetery, crematory or other place)

13 DELLA LANE, BOONSBORO, MARYLAND 21713 20c. Location - City or Town, State

20a. Method of Disposition

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify)

BOONSBORO CEMETERY

BOONSBORO, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

7606 Old National Pike, Boonsboro, MD 21713 Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of) Due to for as a consequence off:

Alherendery

Paul M. Dean

Due to (or as a consequence of):

MINS

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months? I □Yes 2 □ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy

23d. Date of delivery Month

Day

9 Unknown

9 Unknown

5	Oth	er	(sp	ecif	y) _	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♥ No

Year

25. Was case referred to medical examiner? 1∐ Yes 2√2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

autopsy performed? Yes 2 No

24a, Was an

1 ☐ Yes

26. Place of Death (Check only one)

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

871

29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Shut Heightern MD21740

State

31. Date filed (Month, Day, Year) FEB 0 3 Registrar

68 32. Registrar's Signature

A PA

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** Frederick Louis Hiser February 2009 2:00pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Wilson Health Care Center Gaithersburg 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** Year) Months Days Hours 1**⊠** M 2□ F Jan. 09, 1920 Washington, DC 579-09-8570 Director 89 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show 1 XYes 2 No Director Maryland Montgomery Gaithersburg the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with #104 20877 415 Russell Avenue, United States death v Funeral Items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after tent of Health and Mertal Hygiene.
Int: If item 27 is marked other than "natural", or Iten Iny or other traumatic event, the Medical Examinariny or other traumatic event, the Medical Examinatiny or other traumatic event, the Medical Examinatiny or other traumatic event, the Medical Examinating 1 ☐ Never Married 21 Married Baltimore, Maryland 21215-0036 WWII 1 □Yes 2X No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of Energy Certified Public Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Frederick Daniel Hiser Irma Charlotte Boeckstyn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12119 Red Admiral Way, Germantown, MD 20876 Elizabeth Crider (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Heaven Cemetery 2/5/09 4 ☐ Donation 5 ☐ Other (Specify) |Silver Spring, Maryland 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20895 21. Signature of Funeral Service art 1. In er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, nearl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final Physician Ischemic Cardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Valvular Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🖾 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 😿 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural ours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 12+1 February 2, 2009 D 20148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Steven Dolinsky, M.D.

FEB 03

31. Date filed (Month, Day, Year)

22. Registrar's Signature

911 Russell Avenue, Gaithersburg, MD 20877

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Dav **Physician** 1:45 AM William Wilson Higgs February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1⊠ M 2□ F Yrs. 73 Director 220-32-6164 April 1, 1935 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 TYes 2√TNo Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20636 USA 25491 Eva's Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools School Bus Contractor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Roling Higgs 2 Mary Eva Tippett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25491 Eva's Way Hollywood, MD 20636 Agnes Marie Higgs / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 7, 1

Burial 2 □ Cremation 3 □ Removal from State Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Sig of Funeral Service Ligen te 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EP81S S **Physician** /Medical Due to (or as a consequence of): TRACT INFECTION Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PANCREATITIC. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D56096 MD

State Registrar

31. Date filed (Month,

DHMH 17 Rev 1/2001

GILL

24035, THREE NOTCHMD, MOLYWOOD MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Physicia

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	For State Registrar	Olale 0	i wai yian	•		te of L			Territaring	Reg. N	200	9 0	4	115	
	1. Decedent's Name (First, Middle, La	2. Date o Month								me of [	Death				
an al	Ivan V. Harvey		Januar						1, 2009	6:0	)5	P M			
er	4a. Facility Name (If not institution, giv		4b. City	, Town, or	Location	of Death		4	c. County of De	ath					
	608 Hamill Stree				Oakland					_	Garrett				
	5. Social Security Number 6. S	Sex M∑M 2□F	7. Age (In yrs. i	ast birthday) Yrs.		r 1 Year Days	Hours Hours	24 Hrs. Min.	8. Date of Bi	ay, Yea	9. E	Birthplace (S Country)	tate or	Foreign	
	219-14-5533 Usual Residence of Decedent	A –	87	(13.					Dec. 5	, 1	921 Ma	ryland	1		
	10a. State 10b. County 10c. City, Town or Location										10d. Insi	ide Cit	y Limits		
tor	MD Garrett	ak1and	ud.							1 🗆	]Yes	2 No			
irec	10e. Street and Number		_	p Code				10g. (	Citizen of What	 Country?					
al D	1070 Steyer Mine		2	1550				Un	ited St	ates					
ner	11. Marital Status	edent Ever in U.	Ever in U.S. 13. Was I			as Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.)					D- 14. Race - American Indian, Black, White, etc.				
y Fu	1 Never Married 2 Married		2 <b>X</b> No			riioari, c.o.)		Specify:	nte, etc.						
d b	3 Widowed 4 Divorced							Kind of Busines	White						
lete	15. Decedent's Ed (Specify only highest gra	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give						ecedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired)							
i i	Elementary/Secondary (0-12)	College (1	1-4or 5+)	work							Bethlehem Steel				
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last,	)			18. Mother's Name (First, Midd					, Maide	en Surname)				
To B	A. Scott Harvey		Nora Solomen												
						s (Street a	nd Numb	er or Run	al Route Numb	ber, City or Town, State, Zip Code)					
	William Steyer,	nephew		1070	Steyer Mine Rd., Oaklan					d, MD 21550					
	20a. Method of Disposition  1	Bomount from	20b. P	lace of Dispo emetery, crer	osition (Na matory or	me of other place	)	[	Date	20c.	Location - City	or Town, Sta	ite		
	4 □ Donation 5 □ Other (Specif	Cem	etery	-	2/7/	2009	Kitzmiller, MD								
21. Signature of Funeral Service Licensee  22. Name and Address of Facility. David A. Burdock Funeral Home, P.A.															
	21 N. Second St., Oakland, MD 21550  23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate														
	shock, or heart failure. List only Immediate Cause (Final	one cause do	each line.	i. Do not em		12	g, such as	+	T.	49		Interva	al Betw	veen	
	disease or condition resulting in death)														
	Due to (or as a consequence of):														
ner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying														
ami	Cause (Disease or Injury that initiated events														
Medical Examiner	resulting in death) Last														
dica		d								-					
IF FEMALE: 23c. If yes, outcome of pregnancy									001 5 1 1						
cian	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)						23d. Date of delivery  Month Day Y			'e ar				
1   Yes 2   No 9   Unknown 4   Pregnant at time of death 5   Other (specify)   9   Unknown															
Z P	Part II. Other significant conditions	nderlying cause given in Part I. 23e. Did t					tobacco use contribute to the cause of death?								
ed b	(OPD	24a. Wa					☐ Yes 2☐ No 3☐ Probably Unknow				nknown				
plet										dings a	available				
ĕ							topsy prior to completion of cause of death? s 2 ☑ No 1 ☐ Yes 2 ☐ No				iuse oi				
Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only one)													
ျှ	1 Yes 2 No	nt 3 🗆 🗅		4 LI N	ursing Ho			6 Other (S	pecify)						
<u>io</u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury						at ?	7.1	28d. Describe	how in	jury occurred				
2 Accident investigation 3 Suicide 4 Homicide   M 1 Yes 2 No    28e. Place of Injury - At home, farm, street, factory, office    28f. Location (S City or Town)							(Stroot	and Number or	Pural Pouts	Alumi	hor				
erti	4 ☐ Homicide determined	build	ing, etc. (Specif	<i>y</i> )		,,, 011100			City or To	wn, St	ate)	riaras riodic	, , , , , , , , , , , , , , , , , , , ,	,01,	
Sal	29a. Certifier (Check only 2 Medical Exa	hysician: To the	e best of my kno	wledge, deat	th occurre	d at the tin	ne, date a	ind place	, and due to the	e cause	e(s) and manner	as stated.			
Medical Certification: To Be Completed by Physician/A	29b. Signature and title of certifier	and man	nner stated.			9c. License		au occur	TOU ALTITE HITTE		and place, and d				
	and the of defined	1		b	,					⊾ou. I	7700	, Day, 10	/		
VA	30. Name and address of person who	complete caus	se of death (Item	n 23a) (Type		D2397	9				UACT				
3	Dr. Robert A. Go		•			Stree	et, 0	akla	nd, MD	21	.550				
te	31. Date filed (Month, Day, Year)	32. 5	registrar's Signa		arks										
ar	FFB - 5 2	UUU /	LIMB 1	1. 14	P.S. St.										

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Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at

Baltimore, Maryland 21215-0036

Physician /Medica Examine

Division or Vital Records, P.O. Box 68760,

MZL

ia	-	Elizabeth Agne:	s Hyle						. Date of Death Month January		009 009	3. Time of Death 12:55 p M	
ica ne		4a. Facility Name (If not institution, give street Carroll Lutheran Vill.	and nu <b>ffe</b> al c	thcare enter		Town, or L	ster			4c. County of Death  Carroll			
		5. Social Security Number 213–18–9062 1 □ M 2		(In yrs. last birtho	Months		If Under 24 h Hours N	Hrs. 8.	Date of Birth (Month, Day, Jan 22,	<sup>Year)</sup> 1914	9. Birthp Cour Mary	olace (State or Foreign oftry) Land	
		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town of	or Location						14	0d. Inside City Limits	
	ctor	Maryland Carroll		roo. Oily, Town	Location	₩e	stmin	ster				1 Yes 2 No	
1	Be Completed by Funeral Director	10e. Street and Number 250 St. Luke Circle,	09	10f. Zip Code 21158						10g. Citizen of What Country? USA			
	ner	11. Marital Status 12. W	er in U.S.	U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)						e - Americ			
1	Dy F	1 Never Married 2 Married 1 if 3 Widowed 4 Divorced Ye		1 ☐ Yes 2 No Specify: Specify:							white		
	eted	15. Decedent's Education (Specify only highest grade com	pleted)	16a. D	ecedent's Usu Give kind of wo ife. DO NOT u	al Occupati	on ring most of	working	1	6b. Kind of B	usiness/In	dustry	
	E O	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	"	Housew					Own	Home	9	
	10 Be C	17. Father's Name (First, Middle, Last) Calvin Bankert				1	8. Mother's I Mary		First, Middle, M. gling	aiden Surnar	ne)		
ľ		19a. Informant's Name/Relationship (Type. Pr. Jack Hyle, son	19b. N	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Wynwood Drive, Monmouth Junction, NJ 08852							Code) 8852		
		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City cemetery, crematory or other place)  St. Marry C. Comotory (02/04/2009)  St. Iver Ri											
		4 Donation 5 Other (Specify)  21. Signature of Euneral Service Licensee  22. Name and Address of Facility  Myers-Durboraw F								Funer	neral Home		
		91 Willis Street, Westminster, MD 21157											
		23a. Part1 Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final	ns that caused the use op each line	ne death. Do no	t enter the mod	de of dying,	-			7		Approximate Interval Between Onset and Death	
		disease or conditiona	Due to (or as a	onsequence of)	ner-		J-en	n	ant	u _		years	
		Sequentially list conditions b.											
	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
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	Σ	29b. Signature and title of certifier	カの		29	c. License	number	- 0	29	d. Date signe	d (Month,	Day, Year)	
		30. Name and address of person who complete	ted cause of dea	ath (Item 23a) (T	ype, Print)	1100	) J J	D	73	2/2	2/	2007	
		KEVIN BREW	STER	2 Signature	K,109	25 1	DRI	UE,	IAI	UEY;	10w,	N. Md. 18	
tat	P	31. Date filed (Month, Day, Year)	32. Registrar	o oigirature	-						-		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Walter Simpson Harris, Jr. 0920 M February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT Memoria at EASTON ASTON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 02-22-1920 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 220-01-6072 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f st Examiner must be notified Director 1 ☐ Yes 2 ☐ No Md. Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11525 Ridgely Road 21660 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □Yes 211 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Truck Driver S Adkins is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter S. Harris, Sr. Margaret Dyer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Kathi Fletcher/Daughter Harlech Hall, Dover, Delaware 19904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Grove Cem 02-07-09 Denton, maryland 22. Name and Address of Facility Bennie Smith Funeral Home Signature of Funeral Service Lice W. Division St., Dover, De. 19904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0515 /Medical Due to (or as a consequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed sician and burial-trans Myocarc 9+Uc Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) signed by the a Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ ☐ Heknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performe Vital 2 140 1 ☐ Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Departent 2 ER/Outpatient 3 DOA Division of Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical

State Registrar

29b. Signature and title of certifie

Deshields MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219 5 Washington St. Easton, Md. 21601

29c. License number

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Howard Richardson Halsey 2009 12:45P January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 □ F Hours Min. 12-18-1957 Director 218-74-7923 51 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ir. M. dich Evaning the motified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3836 Birdsville Rd. 20776 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ဤNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 💢 No þ Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Bus Repair 12th Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Elwood Halsey Mary Gladys Wilkinson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary W. Cranford/ Mother 360 Marlboro Rd., Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mt. Zion UMC Cemetery 1/27/09 4 ☐ Donation 5 ☐ Other (Specify) Lothian, Maryland Fyneral Servi 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Myocar munediate disease or condition resulting in death) /Medical Examiner ears 2018A22 nev Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit cars Exami er en5100 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No certificate has b irector, page 2 st 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this c
y filled in by the funeral dire 1 Yes 2 4 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 = ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29d. Date signed (Month, Day, Year) 2009 cause of death (Item 23a) (Type, Print) Defense Hyn Suite 400 1/6 2 31. Date filed (Month, Day, Year) JAN 26 2009 Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Ph /N Ex

spital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

To the Hos within 24 ho within 24 ho To the Full completely

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/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea				4c. County of	Death •			
		TENIASULA RESIDANU MEDICAL CEN	10/	54	1456424		W.	comic			
uneral irector		5. Social Security Number 215-56-6161 6. Sex 1 M 2 X F 7. Age (In yrs. In 79	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09/08/19		. Birthplace (State or Foreign Country) aryland			
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28a-	Director	MD Somerset Princess Anne 10g. Citizen of What Country?									
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ms 2;	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - Am									
Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my Injury or other traumatic event, the Review Examiner must be notified at once.	Ş	Armed Forces?  1 □ Never Married 2 □ Married		lfYes, specify Cubar 1 □Yes 2 (No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	White, etc. White			
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Import any Inj		21 Signature of Funeral Service Vicensee  22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853									
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within 24 not/s after beat.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2☑No 9 □Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	23d. Date o Month	•							
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To the	Me	29b. Signature and the of certified		29c. License	number	29	d. Date signed (A	Month, Day, Year)			
		* Robard Marie Des	15/C/A	1 769	4152		01/291	2009			
T		30. Name and address of person who completed cause of death (Item	23a) (Type,			sburv. MD	21801				
Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signat		TOTT DELEG	Les Dalle	,,,, in	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~				
Registr		FER 119 2000 12		her Kel							

1. Decedent's Name (First, Middle, Last) Helen Frances Harrison 2. Date of Death 3. Time of Death **Physician** Francis January 26, 2009 3:57  $p^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATRIA ASSISTED LIVING WICOMICO SALISBURY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 F Months Days Hours 290-14-3299 87 Director <del>04/14/1921</del> Ohio Usual Residence of Decedent 04/04/192 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at **Funeral Director** Delaware Sussex Delmar 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 36109 Bi-State Blvd. 19940 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Belot Ruth Beloat Melvin Bentley ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen A. Harrison/son 36109 Bi-State Blvd., Delmar, DE 19940 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Old Wheelersburg 2/6/09 Sciotoville, OH 4 Donation 5 Other (Specify Cemetery 21. Signature of Funeral Service Licens Holloway Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thrive **Physician** Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ✔ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 **(2)**(No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2MNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 057952 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Milford ST # 504B Salisbury, MD
32. Registrar's Signature Babulal Das. 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Year **Physician** MARY AUDREY HOOPER Feb. 2009 11:03PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Federalsburg Caroline 801 Fairhaven Manor 5. Sociel Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Yeer) Months 213-12-5739 1 □ M 2 🗓 F 92 Yrs Maryland 1916Director 15. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23s or 28s-f sho event, the Medical Examiner must be notified at Federalsburg MD Caroline 1X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours aftar death with inent of Health and Mental Hygiene. United States 21632 801 Fairhaven Manor Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. I ☐ Yes 2√ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify **Black** Š Specify. 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture/Own Home Farming/Homemaker 9 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Crumble Augusta Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) partment of Health and cortant: If Item 27 is mortant in Item 27 is mortann 849 Bullock Ave., Yeadon, PA 19050 Anita Crumble/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/09 Federalsburg, Maryland Federal Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 Muhul 23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine or Attending Physician: The law requires that the death certificate be axecuted physician and s the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): attanding | for use as the ber Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ s been signe 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? certificata has birector, page 2 s ₹ No 1 ☐ Yes 1 ☐ Yes 2 ☑ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 🗍 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 DNatural 5 ☐ Pending 24 hours after death. Funeral Director: A investigation 1 Yes 2 No 2 Accident filled in by tha 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical within 24 hor To the Fune completely fi (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) HOO 67200 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Bloomingdale Ave, Federalsburg. Van trederick Dusen, M.D. 215

Registrar

DHMH 16 Rev 6/95

State

FEB 0 6 2009

32. Registrer's Signature

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral (
completely filled

altimore, Maryland 21215-0036

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature in title of certifie 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DØØ16389 FEBRUARY 11, 2009

C. VALARAO, OLO. 1716 HARPORD Rd Se. 105 PALLSTON HO 21047 PER PECTO

State Registrar 31. Date filed (Month, Day, Year) FEB 18 2009





9+1

JX

Amended #10e, nls, fd
01/29/09, Allegany Co.
1-State
Registrar

Physician

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician	1. Decedent's Name (First, Middle, La	e Hoern	Certificate of	2	Reg. No.	2009	Time of Death
/Medical Examiner	4a. Facility Name (If not institution, given 238 North Cent	e street and number)	4b. City, Town, or	r Location of Death erland	-	County of Death Allegany	101
uneral irector	171-30-0072	Sex   7. Age (In yrs. le			Date of Birth (Month, Day Year) May 12, 1		(State or Fore
Sa-f show	Usual Residence of Decedent  10a. State 10b. County  A Let	3any 10c. City,	Town or Location umberlo	and			nside City Lim
iner nust be notified iner nust be notified Funeral Director	10e. Street and Number 238 North-	Centre Str	al:	502		izen of What Country? USA	
b d	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	S. 13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No		ify Yes or No- can, etc.)	14. Race - American In Black, White, etc. Specify: white	·
t, the Medical E	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done iffe. DO NOT use retired	oation during most of working d)	' '	nd of Business/Industry	
Be even	17. Father's Name (First, Middle, Last		laborer	18. Mother's Name (	First, Middle, Maiden	,	as
If Item 27 is marke or other traumatic	19a. Informant's Name/Relationship John Hoerner	(Type. Print) brother	19b. Mailing Address (Street 22 N. Glenr				1703
ant: If Item ury or other	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Species)	Removal from State	l ace of Disposition (Name of emetery, crematory or other place arpelli Funeral Hom	ie, P.A.		ocation - City or Town, S Cresaptown	State M
Important: Important: any injury o	21. Signature of Funeral Service Liue	see		ଆନ୍ୟୁଲ୍ଲିଆ Hor irginia Avenue:		MD 21502	
ng physician and a street transit as the burlat-transit and page as the burlat-transit and page and pa		b. Due to (or as a consequence.  Due to (or as a consequence.	ence of):			X X	et and Death
for use	I IF FEMALE:	23c. If yes, outcome of pregnar 1	death 3 Ectopic pregnance	у		23d. Date of delivery Month Day	Year
be o	artii. Other significant conditions	contributing to death but not resul	lting in the underlying cause giv	en in Part 1.		se contribute to the car	,
2 N D					24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy fi prior to complet death? 1  Yes 2	ion of cause
irectol	examiner?	Hospital:	ER/Outpatient 2 Dog Oth	26. Place of Death (			
er this eral dir n: To		28a. Date of Injury	En/Outpatient 3 DOA	4 LI Nursing Home	d. Describe how injur		
To the Funeral Director: After this certificate he completely filled in by the funeral director, page:  Medical Certification: To Be Comp	27. Mapner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28b. Time of Injury at Work?  1 Yes 2  28e. Place of Injury - At home, farm, street, factory, office						
the Funeral Capter of the Funeral Capter of	29a. Certifier  (Check only one)  1 Certifying P  Medical Exa	hysician: To the best of my know miner: On the basis of examinati and manner stated.	wledge, death occurred at the ti ion and/or investigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cause(s) I at the time, date and	) and manner as stated I place, and due to the	cause(s)
3	29b. Signature and title of certifier	ner, ~	29c. Licens			te signed (Month, Day,	
	30. Name and address of person who	completed cause of death (Item			-		

DHMH 17 Rev 1/2001

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 2-8-2009 Day Lewis E. Horman /Medical 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-24-1939 7. Age (In vrs. last birthday) **Funeral** 1**™** M 2□ F Months Days Hours Min 212-38-8624 69 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it of Posic - Examinat instruction Director Washington MD Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Columbia Avenue 21742 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 57-64 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify. ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Superintendent Public Works Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis E. Horman Louise Jenny Fouche 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Phyllis Horman Wife 307 Columbia Avenue Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-11-2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Grdn. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licer м01176 106 East Church Street Frederick, MD 21701 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nomon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner 0651 attending physician and for use as the burial-tran law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Lonknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ Mô To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

2008

JRSHED

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month Lay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7:50 AM

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 🗆 No

29d. Date signed (Month, Day, Year)

Year

1 ☐ Yes 2 No

Medical

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

9060396

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 31, 2009 12:40 p T1a Jacobs January Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M AFTER Director 544-18-3796 84 Oct. 13, 1924 Oregon Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Examiner a unt be notified at 1 ☐ Yes > No Director St. Mary's Maryland Leonardtown 10g. Citizen of What Country? 10e. Street and Numbe death with 41997 Loker Court 20650 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify Completed by Specify 3 ☐ Widowed 4 🖾 Divorced White "natural" event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Clerk Dry Cleaners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen McDouga11 Hines Nora ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41997 Loker Court, Leonardtown, Maryland 20650 be of Disposition (Name of Date 20c. Location - City or Town, State Mary Jean Brown/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) jo 📜 5 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. 02/02/2009 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols 21. Signature of Pineral Service Lio 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward W. Stinspield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) attending pl IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performe 1 □Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036



State

29a, Certifie

(Check only one)

29b. Signature and title of certifier

ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed ĺΒ Jarboe, M James

Registrar's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Leonardtown, Maryland 20650

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 11:25 AM Illam 2009 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner ec If Under 1 Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours Year) 10 M 2□ F 92 Yrs. Months Days Min 217-05-4418 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, I'm Medical Evament must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Kton 10g. Citizen of What Country? 10e. Street and Number 192 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delbert son 1651 Lron Koad **Bishop** Jac ewark 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pate/2009 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Strano + Feeley Fami
635 Churchmans Rd. Family Funeral Home Mous alevan Newark, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Y disease or condition resulting in death) arce /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Doe to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) n signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown g to death out not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 🗌 Yes No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 1 □ Yes 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \( \subseteq \text{ Nursing Home} \) 1 npatient ၉ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation Director: / 1 Yes 2 No 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person with ause of death (Item 23a) (Type, Print) NIGZ 5 Muhamme

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

Ammended item #19b per F.D. 1/30/09 CarrollCounty H.D. WSH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Trogotical Company of the Company of							9 04788		
	Physici		Julianty 21, 2007							3. Time of Death 9:30 p M	
	/Medic Examin		4a. Facility Name (If not institution, give 4735 Harney Road	street and number)			Location of Death		4c. County of E	coll	
	Funeral Director		5. Social Security Number 6. Security Number 11		(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth OCC 15,	<sup>Y</sup> <b>1</b> 924 Ma	Birthplace (State or Foreign	
lead	D D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo		Topovitor.			10d. Inside City Limits	
	r 28a-f s	irecto	Maryland Carro	11		10f. Zip Code	Caneytown	1	0g. Citizen of What	1 □Yes 2 No	
	ath with	ralD	4735 Harney Road  USA  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian Black, White, etc.								
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		white white	
15-0	"natur	leted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	king	16b. Kind of Busine	ess/Industry	
2121	filed within Hygiene. wher than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-) <i>me.</i>	Homemake			Own	Home	
Baltimore, Maryland 21215-0036	12 should be filed within 'h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	17. Father's Name (First, Middle, Last) Richard Stevens  18. Mother's Name (First, Middle, Maiden Arabelle Prentis							Maiden Surname) Itiss	len Surname) LSS	
, Mary	1 and 2 sho Health and I lem 27 is ma other trauma	•	19a. Informant's Name/Relationship (Type. Print)  Richard D. James, son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4735 Harney Road, Taneytown, MD 21787								
imore	permit. Pages 1. Department of He Important: If Iten any Injury or oth		20a. Method of Disposition 1 🕱 Burial 2 □ Cremation 3 🕱 4 □ Donation 5 □ Other (Specify			osition (Name of matory or other place en Cemeter		Date 11/2009	20c. Location - City Gettysb		
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	Sulva		2. Name and Addres	ss of Facility M Limore St	lyers—Dur , Taneyt	boraw Fu cown, MD	neral Home 21787	
	23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								est,	Approximate Interval Between Onset and Death	
Jan Jan	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):						
l,	Examiner	er	Sequentially list conditions, if any, leading to immediate	bDue to (or as a	consequence of):						
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
68760,	ificate be executed graphysician and ss the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence of):								
	ertifica Jing ph		IF FEMALE:	23c. If yes, outcome p	of programmy						
.O. Box	The law requires that the death certifice has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23d. Date of Month	delivery Day Year					
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	ınderlying cause giv	en in Part I.			te to the cause of death?  Probably 4 10nknown	
or Vital Records,	The law recate has bee page 2 shou	Completed						24a. Was a autops perfor	med? prior	e autopsy findings available to completion of cause of h?	
/ital	(0 17	Be C	25. Was case referred to medical examiner?				26. Place of Dea	1  Yes th (Check only on	2 No 1 L	Yes 2□No	
or V	di S	은	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 ☐ Inpatier  28a. Date of Injur		III SLI DOA	7, 100 (0,000)				
sion	Attending Physician: r death. ector: After this certific by the funeral director,	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Year) Injury	Wor	k? Yes 2 □ No	zsa. Describe now injury occurred				
Division	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	ry - At home, farm, st . <i>(Specify)</i>	reet, factory, office		treet and Number on, State)	r Rural Route Number,			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best on the basis of and manner state.	examination and/or in	th occurred at the tir nvestigation, in my o	ne, date and place ppinion, death occu	e, and due to the corred at the time, o	ause(s) and manne late and place, and	er as stated. due to the cause(s)	
	√× withii Song	M	29b. Signature and title of certifier	Kuler	MD	29c. Licens	6 number 5 3 9 2	2	9d. Date signed (M	Ionth, Day, Year)	
1	n/P,		30. Name and address of person who				Jen Sha		Sdu . DO	103.157	
2.	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	(A)(A	JG 276	othe	STHINKS	- M21157	
	Regist	rar	JAN 3 0 2009	1 pengua	p. par	Red					

		1 - State of Maryland / Departr	ment of Health and Ment icate of Death	al Hygiene Reg. No	000000000
Physi		1. Decedent's Name (First, Middle, Last) ROGENHAROLD TARRELL	TZ	ate of Death onth Day	
/Med Exam			. City, Town, or Location of Death	2 3	2009 1537 M County ol Death
		6601 Cranesville Rd	OAKCAND		Sarvett
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs. 8. Days Hours Min. 3	ate of Birth Ignth, Day Year)	9. Birthplace (State or Foreign
pue		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	nn .		10d. Inside City Limits
death with the Maryland ma 23a or 28a-1 show	ō	MD Garrett Oakland	,,,		1 ☐ Yes ŽÕ No
288-	Director		Of. Zip Code	10g Cit	izen of What Country?
3a or		6601 Cranesville Road	21550		.S.A.
ē 2 2	/ Funerai	1 Never Married 2 Narried 1 ☐ Yes 2 No	Decedent of Hispanic Origin? (Specify Ys, specify Cuban, Mexican, Puerto Rican,	es or No- , etc.)	14. Race - American Indian, Black, White, etc.
IZI 3-UU36 ithin 72 hours eff ne. nen "neturel", or Medical Exem	d by	3 Widowed 4 Divorced Year or Dates:	res zu no specily.		Specify: White
within 72 ha	ete	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of working IOT use retired)	16b. K	ind of Business/Industry
3 6 2 2	Completed		Blower	Ma	nufacturing
Hygi other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First		
should be nd Mentel marked o	To B	Roger Harold Jarrell,  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Ac	Sr. Barbara		kins
Ma d 2 d 2 d 3 d 3 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2			ddress (Street and Number or Rural Rout $80x\ 283$ , $Cullode$		r Town, State, Zip Code)
s 1 and f Heali		20a. Method of Disposition 20b. Place of Disposition	Name of Date		ocation - City or Town, State
Pages ment of ant: If its		1 🖔 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Cemetery, cremator  Memory Ga		09 Mad	lison,WV
SAITIMORE Sermit. Pages 1: Depentment of He mportant: If Itan			me and Address of Facility Newn	nan Fun	eral Homes P.A.
n goess	a		3 S. Second St.		nd,MD 21550
Physiciai /Medica Examine	1	23a. Part1. Enter the disease, or complications of the death. Do not enter the shock, or heart lailure. List only one such on each line.  Immediate Cause (Final disease or condition resulting in death)  Articulo Scloud  Due to (or as a consequence of):	4	^	Interval Between Onset and Death  AISUS Years
uted d ansit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	OBESITY		year
be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence ol):	OBESITY		year
ob/ou, tificate be executed g physicien and es the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):	OBESITY		year
SOX O ath certifications or use es	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?	onsesity		23d. Date of delivery Month Day Year
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rds, r.C. box or quires thet the death certific in signed by the ettending of uld be detached for use es	by Physician/Medical Examiner	If FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	opic pregnancy er (specify)	3e. Did tobacco u	Month Day Year
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THECOTICS, P.O. BOX Of The law requires thet the death certificate has been signed by the ettending page 2 should be detached for use es	e Completed by Physician/Medical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 k   No   9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying to the significant conditions.	opic pregnancy er (specify)  ying cause given in Part I.  23	3e. Did tobacco u  1  Yes 2 2  4a. Was an autopsy performed? Yes 2 No	Month Day Year  Ise contribute to the cause of death?  No 3 Probably 4 Minknown  24b. Were autopsy findings available prior to completion of cause of
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NI VICAL RECORDS, P.O. BOX O hysician: The law requires thet the death certifical has been signed by the ettending it director, page 2 should be detached for use es	To Be Completed by Physician/Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ppic pregnancy er (specify)  ying cause given in Part I.  26. Place of Death Che  DOA Other: 4   Nursing Home \$  28c. Injury at Work?  1   Yes 2   No	3e. Did tobacco u  1  Yes 2  4a. Was an autopsy performed?   Yes 2 No ck only one lescribe how injur	Month Day Year  Ise contribute to the cause of death?  No 3 Probably 4 Minknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  y occurred
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OT VITAL RECORDS, P.O. BOX Of Physician: The law requires that the death certific this certificate has been signed by the ettending from director, page 2 should be detached for use es	Certification; To Be Completed by Physician/Medical Examiner	If FEMALE:  23b. Was decedent pregnant in the past 12 months? 1	ppic pregnancy ler (specify)  ying cause given in Part I.  26. Place of Death Che  26. Place of Death Che  26. Place of Death Che  28c. Injury at Work?  1	3e. Did tobacco u  1 Yes 2  4a. Was an autopsy performed? Yes 2 No ck only one is Residence rescribe how injure recation (Street and ity or Town, State the time, date and	Month Day Year  Ise contribute to the cause of death?  No 3 Probably 4 Minknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  y occurred  d Number or Rural Route Number.
NI VICAL RECORDS, P.O. BOX O hysician: The law requires thet the death certificate has been signed by the ettending it director, page 2 should be detached for use es	Medical Certification; To Be Completed by Physician/Medical Examiner	If FEMALE:  23b. Was decedent pregnant in the past 12 months? 1	ppic pregnancy er (specify)  ying cause given in Part I.  26. Place of Death   Cher   DOA   Cther: 4   Nursing Home \$   28c. Injury at Work? 1   28d. D   1   Yes 2   No     Nursing Home \$   28t. Logical Color C	3e. Did tobacco L  1 Yes 2  4a. Was an autopsy performed? Yes 2 No ck only one Describe how injured to the cause (s) the time, date and 29d. Date 1	Month Day Year  Isse contribute to the cause of death?  No 3 Probably 4 Minknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  y occurred  d Number or Rural Route Number,  I place, and due to the cause(s)  re signed (Month, Day, Year)
To the Hospital or Attanding Physician: The law requires that the death certification of the Funeral Diractor: After this certificate has been signed by the ettending of completely filled in by the funeral director, page 2 should be detached for use es	edical Certification; To Be Completed by Physician/Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ppic pregnancy ler (specify)  ying cause given in Part I.  26. Place of Death Cher  26. Place of Death Cher  28c. Injury at Work?  1   Yes 2   No  factory, office   28f. Lo  27c. License number  4 26/5 4  1 A Cres Dr. Oa	3e. Did tobacco L  1 Yes 2  4a. Was an autopsy performed? Yes 2 No ck only one Describe how injured to the cause (s) the time, date and 29d. Date 1	Month Day Year  Ise contribute to the cause of death?  No 3 Probably 4 Miknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  y occurred  d Number or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Ε /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner AMPU-If Under 24 Hrs. If Unde Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 □ M 2 🕅 F Yrs Director 215-30-7895 76 Virginia April 13 1932 West Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Exantiment on other traumatic event, the Medical Exantiment on the modified at Director 1 ☐ Yes 2 🕅 No WV Mineral Elk Garden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1, Box 224 Funeral 26717 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 21 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 <u>ک</u> If Yes, Give Year or Dates 1 ☐Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Mineral County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Fisher ೭ Loretta Liller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) April Schwinabart, Daughter 1, Box 224, Elk Garden, WV 26717 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/31/2009 Kalbaugh Cemetery Elk Garden, WV 21. Signature of Funeral Service Licensee David A. Burdock Funeral Home, 710 Church St., Kitzmiller, MD Katherine Guritz 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause/on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 54001 **Physician** nun wil disease or condition resulting in death) /Medical Due to (or as a consequence tof) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 24☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No certificate 2 □ No Division of Vital 1 ☐ Yes 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2∰No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation hours after death. 2 Accident 1 ☐ Yes 2 ☐ No d in by the f 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide in 24 hours.
the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 24 and manner stated

State Registrar

29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Gupta, 625 Kent Avenue, Suite 101, Cumberland, MD

32. Registrar's Signature

29c. License number

1)0033280

29d. Date signed (Month, Day, Year)

, 200

			State of Marylar		ertment of F		nd Mental Hy	/giene Reg. No2 () ()	19 01.	701
3			Registrar  1. Decedent's Name (First, Middle, Last)		incate or	Deam	2. Date of D	41-	3. Time	of Death
	Physici /Medic		RALPH LEON JONES				FEBRUA	ARY Day 2, 20	ŎŨ9 8:	:05 ₽M
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o			4c. County o		
			REEDERS MEMORIAL HOME  5. Social Security Number   6. Sex   7. Age (In yrs	. last birthdav)	If Under 1 Year	OONSBOI	Hrs. 8. Date of Bi		SHINGTON  9. Birthplace (State	e or Foreign
- 1	Funeral Director		212-38-9434 <sup>1⊠M 2□F</sup> 83	Yrs.	Months Days	Hours	Min.   (Month, D	ay, Year) 25, 1925	9. Birthplace (State Country) MARYLAN	
	pui		Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or Lo	cation				10d. Inside	
	//anyla	or		,		MCTOTO				es 211 No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	MARYLAND WASHINGTON  10e. Street and Number		10f. Zip Code	NSBORO_		10g. Citizen of WI	hat Country?	
	th with		5219 AMOS REEDER ROAD			21713		U.	S.A.	
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Was Decedent of H f Yes, specify Cub	lispanic Origir an, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race Black	- American Indian, , White, etc.	
-0036	irs after il", or ite xamine	by F	1 ⊠Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	I□Yes 2 <b>X</b> No	Specify:		Specify:	WHITE	
318	within 72 hours ene. than "natural", he Medical Exa	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup kind of work done	oation	f working	16b. Kind of Bus		
2121	rithin 7 ne. han "r e Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retire	d)	i working	IN TOT T	a garroot	
	filed w Hygiei other th	Col	Name (First, Middle, Last)		CUSTODI		Name (First, Middle		C SCHOOL	
and	ld be ental ked o	To Be	LUTHER MARTIN JONES				ETTA LONG			
Mary	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ig Address (Street		or Rural Route Num	ber, City or Town, S	State, Zip Code)	
FD.	and 2 lealth m 27 i		JAMES JONES/NEPHEW			EDER RO	DAD, BOONS			21713
Name altimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	sition (Name of natory or other pla	i	Date		City or Town, State	
->≣	artmei ortant Injury		4 □ Denation 5 □ Other (Specify) BC  21. Sign ture of Fineral Sarvi Licese		CEMETER  . Name and Addre		/06/2009		RO, MARYLA NERAL HOMI	
& B	permit. Departr Imports any Inj		Paul M. D	loan			1 Pike, B			
ii6	· · · · · · · · · · · · · · · · · · ·		23a. Palt1. Enter the disease of complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,	Approxim Interval B	nate Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	cent.	2 Cord	is Va	ale e	neen	Onset and	
	/Medical Examiner		Due to (or as a conse	quence of):						
\$2.0	i jajo ngga	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):						
	executed n and ial-transit	Examiner	that initiated events						. I	
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a conse	quence of):						
687	ficate   physi	edical	d							
Вох	leath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe		Testania araggana			23d. Date	of delivery	
		Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Ectopic pregnanc Other (specify) _			Mon	th Day	Year
P.(	that the de led by the a detached f	Phy	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tohacco use contri	bute to the cause o	of death?
ds,	law requires that as been signed b	d by	the abullation to	5	sterri	•	1 🗆	]Yes 2□No	3 ☐ Probably 4 €	<b>⊒⊎</b> nknown
S	aw rec s beer 2 shou	olete					24a. Wa	s an 24b. W	Vere autopsy finding	gs available
- E	The lavate has	mo;					— auto per 1□ Yes	formed? de	rior to completion of eath? □Yes 2□No	t cause of
/ita	cian; sertific setor,	Be (	25. Was case referred to medical examiner?		Lou		f Death (Check only	one)		
o	Physic rthis cral dir	- To	1 ☐ Yes 2 ☐ NO Hospital: 1 ☐ Inpatient 2 [  27. Manner of Death 28a. Date of Injury	ER/Outpatien		4 Hours	Ing Home 5 ☐ Res	how injury occurre		-
on	nding th. r: Afte e fune	tion	1 ☐ Natūral 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Wo	rk? ]Yes 2 ⊟ No		now injury cocarre		
Division or Vital Records, P.O.	or Attending Physician; The law requires that the death certificate death.  Director: After this certificate has been signed by the attending to by the funeral director, page 2 should be detached for use as	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Spec	home, farm, str ify)	eet, factory, office			(Street and Numbe	er or Rural Route Nu	umber,
	oital o urs aft eral DI						Į.	,		
	e Hosp 24 hol e Fune etely f	Medical	29a. Certifier 1 [☐eertifying Physiclan: To the best of my kr (Check only one) 2 ☐ Medical Examiner: On the basis of examiner and manner stated.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time	e cause(s) and mar e, date and place, a	iner as stated. and due to the cause	e(s)
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed	(Month, Day, Year)	)
			- Jumo		DIE	8019		FEB 3	,2009	
S	4-4		30. Name and address of person who completed cause of death (Ite DR. VASANT DATTA 340 MILL		Print) HAGERST	OWN,	MARYLAND	21740/301	-739-7100	0
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature						
	Regist	rar	FER 0.5.2009	1 1	alle					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 2009 Jesse G. Johnson 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death salis bure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) B. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Year) Days 1 XM 2 ☐ F North Carolina June 12, 1936 246-48-3476 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Delmar Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21875 U.S.A. 29661 Foskey Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 2□No 1956-1 ☐ Yes 2XXNo Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 1960 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Retail District Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Cantrell

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

Edgar G. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29661 Foskey Lane Delmar, MD 21875 (Wife) Martha J. Johnson Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Crematory of Delmarva Feb. 2, 2009 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee

13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final STAGE END

disease or condition resulting in death) Due to (or as a consequence of):

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Afther (Specify) HOSPI G 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 2 ☐ 110 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 □Yes 2 □No

2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29d. Date signed (Month, Day, Year) 29c. License number DO058410

23d. Date of delivery

Day

Month

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O DOX 1733 SAUSBURYUD 21 DASTON Huston WAM 31. Date filed (Month, Day, Year)

State Registrar

**Physician** 

**Examiner** 

**Funeral** 

Director

res 1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene.

Pages 1 and 2 should

Department of Important; If it any injury or o

**Physician** 

/Medical

Examiner

the burial-trans

attending physician for use as the buria

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signed t I be deta

ficate has been siç r, page 2 should b

certificate director,

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Afte-1

ithin 24 hours after death.

o the Funeral Director: A completely filled in by the fu hours after death.

funeral

the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-003

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

/Medical

10a State

MD

Funeral Director

Completed by

Be

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

25. Was case referred to medical examiner?

29b. Signature and title of certifier

FEB 03



09-01165 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Andrew Jackson State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 9, 2009 Year 0344 hrs **Medical Examiner** Andrew Jackson Andrew Jackson Jones 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Smithsburg Washington 2222 Jefferson Boulevard 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Country) Maryland Director Dec. 22, 1990 219-31-0232 18 1 X M 2 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location l0b. County 10a. State 1 X Yes 2 No 28a-f show Maryland Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 143 E. Antietam St. Apt. USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes black f Yes, Give Year Divorced Yes 2 X No specify: Specify: 72 hours after Widowed ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than " more, MD 21215-0036 Pages I and 2 should be filed within 7 nent of Health and Mental Hygiene. 11 student high school 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Sandra Marie Fowler Jonathan Jones Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Marie Fowler - mother 143 E. Antietam St., Apt. 2, Hagerstown, Md.21740 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State 2/13/2009 Rose Hill Cemetery Hagerstown, Maryland Importans Other Specify ture of Funeral Service Dice Se 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. Approximate Interval Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Multiple injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical #1, 23a,2/,perME, g888 2/27/09 TT **AMENDED** attending physician or use as the burial -X UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. ģ Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? 1 🗸 Yes ✓ Yes 2 No 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Division of Vital Be Other<sub>4</sub> examiner? Hospital: . DOA Nursing Home 5 Residence 6 V Other: Scene this Inpatient 2 ER/Outpatient 3 1 Yes 28d. Describe how injury occurred
Driver in Motor vehicle After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural Yes 2 X No Pending To the Funeral Director: completely filled in by the 2/9/2009 3:28 am Crash 2X \_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2222 Jefferson BLvd 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) Roadway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME February 9, 2009 30. Name a addr s of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Fegistrar's Signatur State Registrar

Physician /Medical Examiner

within 72 hours after death

Maryland 21215-0036

Baltimore.

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

cate has been sig , page 2 should b funeral director, After s after dea... ai Director: Aft

filled in by

Medical

To the Hospitai c within 24 hours af To the Funerai D completely filled in

Be Certification:

1□ Yes 2XNo

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

5 Pending investigation 1X Natural 2 ☐ Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and tipe of ceptifier 9

D0061083

29d. Date signed (Month, Day, Year) January 30, 2009

30. Name and address of p mon who completed cause of death (Item 23a) (Type, Print)

Paul Thambi, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850 32. Registrar's Signature

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

Registrar

Janks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 **Physician** Wilda Viola 09 Kelly ŎΪ 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖫 F Months 214-07-4054 89 Maryland Director Sep 29 1919 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinating motified an once. Allegany MD Westernport 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22509 Minnetonka Ave 21562 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: ģ Specify: White No 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Arnold Martha McBride ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Kelly/Son 22509 Minnetonka Ave., Westernport, Md 21562 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philos Cem 2/4/09 Westernport, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home, 111 Church St, Westernport, Md 21562 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-transi and Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 hknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 1 ☐ Yes 2 No spital or Attending Physician: Thours after death.
Ineral Director: After this certificate y filled in by the funeral director, pa 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ↑ Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.O. Box 68760, certificate be Division of Vital Records, To the Hospital within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

MO esus lan 31. Date filed (Month, Day, Year) 2 2009 Broadway 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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		_	For State	State of IVI	•		cate of L			0000	01.707
			Registrar  1. Decedent's Name (First, Middle, La	st)		Oerune	ate of L	Jean	2. Date of Dea	th	3. Time of Death
	Physicia		EMMA ELIZABETH K						Janua	Day Year	0 000
1000	/Medic Examin		4a. Facility Name (If not institution, giv			4b.	City, Town, or	Location of Death	1	County of De	
	a	J.	- harles	nwot		<		ONSVI	lle		MOTE
	Funeral		Social Security Number     6. S	Sex 7. Ag	ge (In yrs. last birt	hday) If U Yrs. Mor	nder 1 Year iths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JUL 5,	(Year) 9. B	irthplace (State or Foreign Country)
	Director		213-10-1698 Usual Residence of Decedent	Z III Z ZZZ	90	115.			JUL 5,	1918 AI	RGINIA
	/land		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	a-f st	cto	MD BALTIN	MORE	CAT	ONSVI	LLE				1X Yes 2 □ No
	or 28	Director	10e. Street and Number			10	f. Zip Code			10g. Citizen of What 0	Country?
	ath w	ra	719 MAIDEN CHOIC	T			212			US	
	ltems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🗶		13. Was L	specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	14. Hace - An Black, Wh	nerican Indian, ite, etc.
920	urs af	2	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	,	1 □ Ye	es 2XNo	Specify:		Specify: WE	I <b>T</b> E
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show deal Evaniher rust be retified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a.		Usual Occupa	ation during most of work	cina	16b. Kind of Busines	s/Industry
21	within iene.	nple.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO No	OT use retired,	)	9	th officers	
	should be filed within and Mental Hygiene. marked other than imatic event, the Mental than than the Mental tha		12	0		CASHI	<u>K</u>	18 Mother's Nam	o (First Middle	CLOTHIN Maiden Surname)	lG .
Maryland	d be fi	Be	17. Father's Name (First, Middle, Last, WILLIAM HENRY B)						MCWILLI.		
Z	2 should I and Men is marke aumatic	၉	19a. Informant's Name/Relationship		19b.	Mailing Add	dress (Street a			r, City or Town, State	, Zip Code)
	and 2 sealth a n 27 is		DENISE A. NIX/COL		2	7 NOR	THAMPTO	ON ROAD,	TIMONIU	M MD 21093	
J.	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner is at the notified at		20a. Method of Disposition	75	20b. Place of cemeter	Disposition	(Name of or other place	e)	Date	20c. Location - City of	or Town, State
Ē	Pa ant: ury		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the contro					PARK 2/2	2/2009	EASTON, M	IARYLAND
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr ODCE.		21. Signature of Funeral Service Lice	nsee		22. Nar <b>FEL</b>	ne and Addres	ss of Facility <b>HELFENBE</b>	IN & NEW	NAM FUNERA	L HOME PA
	20 = 6 O			NERCERO.		200	S. HAI	RRISON ST	EASTON	, MD 21601	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each l	d the death. Do i	not enter the	mode of dyin	g, such as cardiad	or respiratory ar	rest,	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a	amou						Meek
	Examiner			( ) (	a consequence	bet	insti	ce Pial	M TIA GLEVA	Disease	42215
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	a consequence	of):	oic   11	, , , , , , ,	1001001	12120036	3000
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9 X	certificat nding phy ise as the	Physician/Medi	IF FEMALE:	23c. If ves, outcome	e of pregnancy					23d. Date of d	delivery
Box	death one atten	ciar	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	4 ☐ Pregnant	2 Fetal death at time of death		pic pregnancy er (specify)	/		Month	Day Year
P.O.	that the c ed by the detached	hysi	9 Unknown	9 🗆 Unknown						i	
	w requires that the designed by the should be detached	oy P	Part II. Other significant conditions	contributing to death	but not resulting in	the underly	ing cause give	en in Part I.			to the cause of death?
ord	requires t seen signe hould be o	Completed by		<u>.                                  </u>					1 🗹 Y	′es 2 □ No 3 □	Probably 4 🗍 Unknown
ec	law r las be	ple							24a. Was autop	an 24b. Were	autopsy findings available o completion of cause of
E	: The cate h	Con							perfor 1 □ Yes	rmed? death 2 ☐ No 1 ☐ Yo	? es 2□No
Division of Vital Records,	Physician: The law this certificate has ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Othe	or: 1	th (Check only o		
of		Certification: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of In	ient 2 ☐ ER/Ou jury 28b.	Time of	28c. Injur	4 Mursing H		dence 6 Other (Si	pecify)
on	Attending Phir death. ector: After this by the funeral of	ation	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay, Year)	njury N		ć? Yes 2 □No			
Vis	er des rector	tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of it	jury - At home, fa etc. <i>(Specify)</i>	rm, street, fa	actory, office	·	28f. Location (S City or Tox	Street and Number or	Rural Route Number,
Ö	ital or irs aft ral Di										
	Hosp 4 hou Funel tely fil	ical	(Check only 2 Medical Exa	miner: On the basis	of examination ar					cause(s) and manner date and place, and d	
	To the Hospital or Attendl within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	one) 29b. Signature and title of certifier	and manner s	tated.		29c. License	e number		29d. Date signed (Mo	onth, Day, Year)
			12000151		1.1		50	7000			
	TLS		30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)	107	100	-4	JUNATA	21,200
	12		Phillip Sto	15.9n	1 Mais	den	/ 1	oice L	ane T	Baltimar	27,2009 MD 21228
		ate	31. Date filed (Month, Day, Year)		trar's Signature	1.	11		1		7
	Regist	rar	JAN O V	CUUJ LENU	m B.	MAN					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 12:45 PM February Clara Ann Kuehn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collington Life Care Community Prince George's Mitchellville 8. Date of Birth (Month, Day, Nov 25, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 XF Months Days Hours Minnesota 569-36-9854 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Prince George's Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examina must be nappea. 20721 USA 10450 Lottsford Road #214 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. If Yes, Give Year or Dates: 1943-64 Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Navy Commander 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Kroening Edward Kuehn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10450 Lottsford Road #214 Mitchellville, MD 20721 Norma J. Robinson/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory 02/04/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service 21. Signature of Funeral Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner b. Cerebralvascular Accident weeks Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a conseque years attending physician and for use as the burial-tran ue to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown nis certificate has been s director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death. Re Funeral Director: A pletely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

15+1

within 2 To the I

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael LaPenta, M.D. 445 Defense Highway Annapolis, MD 21401 32. Registrar's Signature

and manner stated

29c. License number

38

29d. Date signed (Month, Day, Year)

February 4, 2009

State of Manyland / Department of Health and Montal Hygiene

			For I_ State	tate of Mary				/lental Hy	00	0.0	017	
e e			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of De	Reg. No. Z	UY	Time of D	99 eath
	hysicia		JAMES FRANKLIN KIM	BLE				Month JANUAR	Day	Year	8:59	<b>P</b> M
	/Medic xamin		4a. Facility Name (If not institution, give stre		· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or	r Location of Death		4c. County		0.57	
74.		der	325 WILLOW BRANCH			CENTRE If Under 1 Year	VILLE If Under 24 Hrs.	Lo Data of B		N ANNE		
	ineral ector		5. Social Security Number 6. Sex 1219-30-1496		n yrs. last birthday) <b>'5</b> Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di	4, 1933	9. Birthplace Country) MARYL		Foreign
			Usual Residence of Decedent					IMIKOH	4, 1755			
arytar	show d at	7	10a. State 10b. County		c. City, Town or Lo						Inside City 1 ☐ Yes 2	**
the M	28a-f notifie	Director	MARYLAND QUEEN AND  10e. Street and Number	E.S	CENTREV	10f. Zip Code		Ī	10g. Citizen of V			
with	3a or		325 WILLOW BRANCH	ROAD		21617				D STAT		
death	ems 2	Funeral		Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an. Mexican, Puerto	pecify Yes or No Bican, etc.)		e - American l	Indian,	
OU36 hours after death with the Maryland	or it	by Fu	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give 9.55- Year or Dale 9.55-		1 □ Yes 2 No	Specify:	,		WHITE		
5-0036 72 hours af	"naturai", or items 23a or 28a-f show idical Examiner must be notified at		15. Decedent's Educat	on	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu			
vithin 72 ene.	r than "natul the Medical	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done DO NOT use retired	during most of work d)	king				
N D D	t, the	Con	12		FAI	RMER			FARM			
E e e E	ed other event,	Be	17. Father's Name (First, Middle, Last)  JAMES WEBSTER KTM	מו זם			18. Mother's Nam	, ,	,	ne)		
> 5 ×	EE	၉	19a. Informant's Name/Relationship (Type.		19b. Maili	ng Address (Street	GEORGIA and Number or Ru			State, Zip Co	de)	
E Pa	27 is er trau	1	MARGARET ALICE SPRAY	KIMBLE/W								
es 1 a of He	if Item or othe	ı	20a. Method of Disposition 1    Mathematical Burial 2 □ Cremation 3 □ Rem	2	20b. Place of Dispo	osition (Name of AMAT) OYother place	i	Date JARY 5	20c. Location -			
altimore, mit. Pages 1 a partment of Hea	tant: i Jury o		4 □ Donation 5 □ Other (Specify)	Ovar Ironi State	CEMETE	RY	20	09	CHURCH			
balt permit. Depart	Important: any injury once.		21. Signature of Juneral Service Licens	Elfenhu	$\frac{2}{4}$	2. Name and Addre ELLOWS, H 08 SOUTH	ELFENBELL LIBERTY	N & NEW STREET,	NAM FUNE CENTREV	RAL HO	ME, P MD 21	.A. 617
	4 -		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ions that caused the ause on each line.	death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory	arrest,	Init	proximate terval Betweenset and De	een
	sician edical		Immediate Cause (Final disease or condition resulting in death)		Lun	a Ca	ncer				$\frac{1}{2}m$	
	miner			Due to (or as a co	onsequence of):	0						
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):							
ecutec	transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
cate be executed	ysician and ie burial-transit	a E	resuming in death, east	Due to (or as a co	onsequence of):							
<b>S</b> 8	등 등	edical	d									
. BOX C	attending   for use as	M/us	23b. Was decedent pregnant	If yes, outcome pf p 1□Live birth 2□		⊒Ectopic pregnanc			23d. Da	te of delivery		
. 0	the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim		Other (specify)	у		Mo	onth Da	y Ye	ar
P. C	ed by t detach		Part II. Other significant conditions contril		ot resulting in the u	ınderivina cause aiv	ven in Part I.	23e. Did	tobacco use cont	tribute to the c	ause of dea	ath?
VITAI RECORDS, P.O.	been signed by the should be detached	d by		<b>3</b>		,			Yes 2□No	3 Probabl		
S ME	s beer	Completed						24a. Wa	s an 24b.	Were autopsy	findings av	/ailable
	certificate has t frector, page 2 s	mo						auto peri 1∐ Yes	formed?_	prior to compl death? 1 □ Yes 2 □		ise of
/ <b>Ita</b> clan:	ertifica ector, I	Be C	25. Was case referred to medical examiner?				26. Place of Dea					
Or /	this c al dire	ဥ	1 ☐ Yes 2 ☑ No Hos  27. Manner of Death	pital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 LI Nursing H		sidence 6 Oth			
On ding	: After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Injury	Wor	rk?  Yes 2∐No	200. Describe	how injury occur	rea		
DIVISION OF I or Attending Phy after death.	ector by the	Certification:	e Could not be	28e. Place of injury building, etc. (8	- At home, farm, st				(Street and Numb	per or Rural Re	oute Numbe	e <i>r</i> ,
ital or	rai led in	Cert							own, State)	<u>.</u>		
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death.	he Fune pletely fii	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examíne	ian: To the best of mer: On the basis of ex and manner stated	amination and/or it	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the irred at the time	e cause(s) and ma e, date and place,	anner as state and due to th	ed. e cause(s)	
To the within	To t	Ž	29b. Signature and title of certifier	1/1		29c. Licens	se number		29d. Date signe	ed (Month, Day	y, Year)	
10	205		/	V	- A	L	662	10	2-0	2-0	9	
17	111		30. Name and address of person who com  DAVID HALVERSON, M			, Print) <b>LVE, SUIT</b> .	E 302. EA	STON. 1	MARYLAND	21601		
F	Sta Registr		31. Date filed (Month, Day, Year) FEB - 3 2009	37. Registrar's	Signature .							

DHMH 17 Rev 1/2001

Box 68760, P.O. I Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year) FEB 0 6 2009

Decelor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

10:500



0/5

29c. License number

40061

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Anita Kerns 26,2009 102 lan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wicomico lisbury Rehabilitation+Nursing Ctr lis Ch 064 5. Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 214-28-8056 Director 11/20/1931 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Roger St. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: ð Specify: 3 → Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sales retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Adams Bertha Brittingham ပ 19a. Informant's Name/Relationship (Type. Print)
Robert Williams/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1126 Resden Run, Salisbury, MD 21804 or other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/29/09 Salisbury, MD 21. Signature of Funeral Service Lice 22 HOTTOWAY FUNETAL Home Professional Association Kell Snow Hill Rd., Salisbury, MD 21804 IRRE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician of. disease or condition resulting in death) Reco /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and hed for use as the burlal-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No. 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 4NG director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

that the death certificate be execu Division of Vital Records. P.O. Box 68760. Hospital or Attending Physician: 24 hours after death, To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A

21215-0036

Maryland

Baltimore,

State

Registrar

Medical

29a, Certifie

(Check only one)

29b. Signature and title of certifie

William H. 31. Date filed (Mont) Div

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins, M.D. &

2000

1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

sivic Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 1222 P M **KELLER** FEB. ANITA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □X Months Days Hours Min Yrs. Director 60 APR. 18, 1948 MARYLAND 218-44-4277 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 XNo Director DELAWARE SUSSEX SELBYVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 37858 CEDAR ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: Completed by Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 Is marked other Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12 POULTRY PROCESSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY FREDERICK VITEK LENA ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37858 CEDAR ROAD, SELBYVILLE, DELAWARE 19975 WILLIAM F. KELLER/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 2/3/09 4 ☐ Donation 5 ☐ Other (Specify) DELMAR, DELAWARE 21. Signature of Lineral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** COPI disease or condition resulting in death) EW YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus. (Classe or n ju that initiated events resulting in death) Last Examine Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION, CHOIESTEROLEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Cunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 263 SNOW ST. SNOW HILL, 14D, 21863

Registrar DHMH 17 Rev 1/2001

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Vital

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Division

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land

Mary

Baltimore,

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WORTH.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:00 PM February 1, 2009 Mary Loretta Lawrence 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 1, 1936 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 □ M 2 1 F Maryland 217-32-3735 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Colton's Point St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20410 Colton's Point Road 20626 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: 3 tv Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Department Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Edith Hill Zachary Joseph Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36329 Mill's Point Road Chaptico, MD 20621 James Dale Lawrence / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 7, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gardens Leonardtown, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 uchael 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepatic encentalopathy Metastatic Cancer. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Month Year in the past 12 months? 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fam dice 2☑No 3☐ Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Injury 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. attending pl o. ۵. Records, Divísion or Vital the Hospital or Attending Physician: ore

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Physician/Medical

**Funeral** 

Director

nd 2 should be filed within 72 hours after death with the Marylan thith and Mental Hygiene.

27 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner.

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any Injury or other traum once.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

일 State

Completed by 25. Was case referred to medical examiner? Be 1 Yes 2 No ဥ 27. Manner of Death Certification: 1 Natural neral Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifle D0060473 02/02/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 Leonal Hown MD &0650 St. Mary 1 Huspital

31. Date filed (Month, Day, Year)

**FEB** 

32/Registrar's Signature

Mehrdad Akhlagh

Registrar

			For State Registrar	1104		f Marylar	nd / Depa		t of H	lealth a		lental Hy	aiene	_		04804
	Physici	an	1. Decedent's Nam Ceil	e (First, Middle	, Last)		r1					2. Date of De		, 200g	ır	3. Time of Death
	/Medi	al		If not institution	, give street and nu		Loeb	4h City	Town or	Location of	of Death	Janua		County of De		6:40 P M
-	Examir	ier	Casey Ho		, give once and man	(IDOI)			kvil		or Dedar			ntgoen		
	Funeral		5. Social Security N		6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)	9. E	Birthpla Countr	ace (State or Foreign
	Director		579-56-1		1 L M 243 F	93	Yrs.	IVIOIIII	Days	riours	IVIIII.	11/04	/1915		1ar	
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27	Mary	to	MD	Montgo	mery	Вез	thesda								ľ	1X Yes 2□No
	or 28	Direc	10e. Street and Nu					10f. Zip					10g. Citi	izen of What	Countr	y?
	ath wi	ral	7420 Wes	tlake T	errace, #				0817					ed Sta		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Exerciting must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed		Armed Fo	ve	1	Was Deced If Yes, sped 1 □Yes		ispanic Ori an, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-	14. Race - Ar Black, Wh Specify: W	nite, et	C.
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lan	ild be fental rked c	To Be	Louis Sh	elpark						Sara	h "U	nknown'	ı			
ary	shou and N is mal		19a. Informant's N	ame/Relationsl	nip (Type. Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rur	al Route Numb	er, City o	r Town, State	e, Zip C	Code)
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Ba	Depariment Deparement Important Information Informatio		21. Signature of Fu									Memori e Rock		hapels e, MD	, I 208	nc. 52
	Physician /Medical	8 VI	23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final on	a	aused the deat ach line. raceret	oral He			g, such as	cardiac	or respiratory a	arrest,		í	Approximate nterval Between Onset and Death
	Examiner		Commontially list on			ial Fib		ion								
,160,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list co cause. Enter Unde Cause (Disease or that initiated events resulting in death)	erlying injury s Last	c	or as a conseq										
P.O. Box 687	Attending Physician: The law requires that the death certificate refeath. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 1 9 □ Unknown	months? ⊒No		oirth 2 Feta nant at time of	al death 3	⊒Ectopic p ⊒Other (sp		y				23d. Date of c		/ ay Year
	w requires that s been signed b should be deta	2	Part II. Other signi	ficant condition	ns contributing to de	eath but not res	ulting in the u	nderlying c	ause give	en in Part I.						cause of death?
Vital Records,	ician: The law ก certificate has be ector, page 2 shr	Completed									<del></del>	24a. Was auto perfe 1 □ Yes		prior t	o comi	sy findings available pletion of cause of
Ζİ	sician: certific rector,	Be	25. Was case referexaminer?	7	Hospital:				Othe			(Check only		17.		TT
of	g Phys er this eral dii		27. Manner of Deat		28a. Date	Inpatient 2  of Injury	28b. Time o		8c. Injun Work	7 🗀 140		me 5 ☐ Resi 28d. Describe			oecify)	Hospice
Division of		Certification: To	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 ☐ Pending investig 6 ☐ Could redeem	ation	th, Day, Year) of Injury - At h ng, etc. (Speci	Injury ome, farm, str fy)	М	1 🗆 '	? Yes 2 ∐ I	No		Street an	d Number or	Rural I	Route Number,
	Hospita 4 hours Funeral	Medical Ce	29a. Certifier (Check only one)	Certifying Medical	g Physician: To the Examiner: On the b	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred	at the tir	ne, date ar pinion, dea	nd place, ath occur	and due to the	e cause(s) , date and	) and manner I place, and d	as sta	ted. he cause(s)
+ •	To the l	Me	29b. Signature and	vitle of certifier		6	<i>i.</i> /	1	License	e number				te signed (Mo		
	July 3				who completed caus				ve	Rocky	7 <b>i</b> 11€	e, MD 2	0850			
	Sta Registi		31. Date filed (Mon	B 02	2009 Ben	egistrar's Signa	ature fran	Kel								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Linda Leonard January 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1010 Sandstone Court Salisbury Wicomico 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9/20/1937 9. Birthplace (State or Foreign Qountry)
Oh10 **Funeral** Months Days Hours 1 M 2 X F 71 294-32-6077 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Musical Examination and Injury or other traumatic event, I'm Musical Examination and Injury or other traumatic event, I'm Musical Examination. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 □ No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Sandstone Court 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2√ No Specify Be Completed by 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oldrich Tichy ဥ Florence Hendricks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Bishop Dr. Framingham, MA 01702 Lesley Leonard/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Salisbury Crematory 1/31/2009 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HOLLOWAY Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** congestive Jan disease or condition resulting in death) anmore /Medical Due to (or as a consequence of): Examiner Menoschiotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate breast clince 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 ₩o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending death. after death 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. DIVISION ST. 1346 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 State		artment of Health and rtificate of Death		0000 01000
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	inicate of Death	Reg.	No. 2 0 0 9 0 4 8 0 5
	Physicia					Month	Day Year
mark.	/Medic Examin		Margaret Lindsey  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat		y 5,2009 1:50 P <sup>M</sup> 4c. County of Death
7	Examin	ei	9000 Goldfield Place				
-	Funeral			e (In yrs. last birthday)	Clinton If Under 1 Year   If Under 24 Hrs	<ul> <li>I 8. Date of Birth</li> </ul>	Prince Georges  9. Birthplace (State or Foreign
	Director		230-58-8909 <sup>1□ M 2</sup> F	65 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Country)
	р .		Usual Residence of Decedent			1149.207	VA
	show	_	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Ba-f	Scto	Md. PG	Clint			1 <u>X</u> Yes 2 □ No
	vith th	Ë	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show that it a fredical Exacultar must be rediffed at	Funeral Director	9000 Goldfield Place		20735		ited States
	er de	Ë	11. Marital Status 12. Was Decedent Armed Forces?		Nas Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 □ Never Married 2 ☆ Married 1 □ Yes 2 ▷ If Yes, Give Year or Dates:		☐Yes 2█ No <i>Specify:</i>		Specify:
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<u>la</u>	Ald be Aentz rked fic ev	일	James Robinson		Annie	Word	
Maryland	s ma		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Number or R	ural Route Number, Cit	ty or Town, State, Zip Code)
Ž	and 2 salth 127 i		Pamela Quigley/daughte	r   2000	Goldfield Platon, MD. 2073	ce	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, trainfection Examined must be a refilted at once.		20a. Method of Disposition	20b. Place of Dispos	sition (Name of hatory or other place)	Date 20c.	Location - City or Town, State
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at	permit. Departi Importa any inj	ı	21. Agnature of Funeral Service Licensee				Edwards F.H.
<u> </u>	89 <b>= 89</b>		June Zawa	02 39	10 Silver Hill	Rd., Sui	tland, Md. 20746
			23a/Par/1. Enter the disease, or complications that caused spock, or heart failure. List only one cause on each lit	the death. Do not ente	er the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
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æ	o - o	ם				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
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₹	sician: certific irector,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie		Othor	ath (Check only one)	
Division of Vital	Phys or this oral dir	2	27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpatien	1 3 DOA 4 D Nursing F	lome 5 Residence 28d. Describe how in	6 Other (Specify)
0	ding Ph th. : After thi s funeral o	įį	1  Natural 5  Pending (Month, Da 2  Accident investigation	Y Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	200. Describe flow in	july occurred
<u> S</u>	il or Attend after death Director: /	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Inju	ury - At home, farm, stre		28f. Location (Street	and Number or Rural Route Number,
É	al or after	Certification:	4 Homicide determined building, etc	c. (Specify)	in the state of th	City or Town, St	ate)
	spita hours mera y fille	- 1	29a. Certifier  17 Certifying Physician: To the best	of my knowledge, death	occurred at the time, date and plac	e, and due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director: After this certification pletely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis o	t examination and/or inv	restigation, in my opinion, death occi	urred at the time, date a	and place, and due to the cause(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	ž	29b. Signature and Itle of certifier		29c. License number		Date signed (Month, Day, Year)
			Jose Mento		D64153	70	1069
		ļ	30. Name and address of person who completed cause of d	eath (Item 23a) (Type, F			
			JOSE L MEMOOS	75	525 GIBBEN WAY (	TR DK, CREE	WELL WO 5020
	Stat		31. Date filed (Month, Day, Year) Registra	ar's Signature			

DHMH 17 Rev 1/2001

Dr.

				artment of Health and N		ene 2009	9 04807
	hysicia		1. Decedent's Name (First, Middle, Last)  Roland I. Molineaux, Jr.		2. Date of Death Month February	Day 1, 2009	3. Time of Death 11:42 p <sup>M</sup>
	/Medica		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
/ -			Laurel Regional Hospital	Laurel		Prince G	eorge's
	ineral rector		5. Social Security Number 220-96-4789 6. Sex 1 1 1 2 1 1 1 1 1 2 1 1 1 1 1 1 1 1 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, ) July 18,	rear)   Co	thplace (State or Foreign ountry) w Jersey
pur	<b>3</b> (2)	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li	ocation	_		10d. Inside City Limits
laryla	sho	5					1 □ Yes 2X□No
the M	28a-1	Director	Maryland Anne Arundel Lau  10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	
with	3a or		3331 Yellow Flower Road	20724	100	USA	ountry:
Jeath	38 2%	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am	erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene.	al", or iter	ρ	Armed Forces?  1 □ Never Married 2 Married	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, Whit	te, etc.
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filed	ent, I	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		nousing Asso
uld be Menta	rked itic ev	면 일	Roland I. Molineaux	Jean Roc	chford		
nd 2 sho alth and	27 is me er traume			ing Address <i>(Street and Number or Rui</i> 331 Yellow Flower			
ges 1 a t of He	if item or othe		11 IBURIAL 2 IXI CREMATION 31 I BEMOVAL from State 1	matory or other place)	Date 20	c. Location - City or	Town, State
t. Pag	rtant:		4 □ Donation 5 □ Other (Specify) Metropol	itan Crematory 2	2009		a, Virginia
perm	any ir			2. Name and Address of Facility Fancis J. Collins			
		+	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	00 University Blvd			ing, MD 2090 Approximate Interval Between
Phys	sician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	- 11			Onset and Death
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ate be executed	physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c				
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at the	d by th	hys	9 ☐ Unknown				
quires th	signe be d	þ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.			o the cause of death?
aw rec	as bee 2 shou	Completed			24a. Was an	24b. Were a	utopsy findings available
	pag	Som			autopsy performe 1 □ Yes 21		
cian:	certificate ector, pag	Be (	25. Was case referred to medical examiner?		th (Check only one)		
physi	this o	ဥ	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatie			ce 6 □Other (Spe	ecify)
Attending Physician: r death.	or: After	ation	27. Manner of Death  1	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
ai or Att	I Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
To the Hospital or Attending Physician: within 24 hours after death.	Funera etely fille	edical (	29a. Certifier (Check only one)  **CertifyIng Physician: To the best of my knowledge, dea 2 Medical ExamIner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occur	, and due to the cau	use(s) and manner a e and place, and du	as stated. e to the cause(s)
<b>To th</b>	To the	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Mon.	th, Day, Year)
M			1 hm V. Lucken	D22966	f	Ebruary	2, 2009
			30. Name and address of person who completed cause of death tem 23a) (Type Thomas H. Burguieres, MD 7300 Van	Print) Dusen Road, Laure		- 1	
	Stat Registra		31. Date filed (Month, Day, Year) FEB 0 3 2009  Attention 5. Sa			-	
			and the second of the	Market .			

			For State	State o	of Marylar	id / Depa	artment of F rtificate of	lealth and			2009	0480
	_		Registrar  1. Decedent's Name (First, Midde	lle Lasti			- Inicate of I	Dealli	2. Date of De	Reg. No.		3. Time of Death
	Physici	an		Eva T. Mende	lcon				Month	Day	Year	8:45 pM
day	/Medio		4a. Facility Name (If not institution				4h City Town o	Location of Deat	January	29	2009	0:43 pm
	Examir	ıer					, ,		1	40. Cour	nty of Death	
	Formula		7420 Westlake 3 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	Bethesda   If Under 24 Hrs.	8. Date of Bir	th		gomery place (State or Foreign
	Funeral Director		043-28-5455	1 □ M 2 🖾 F		Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Coui	ntry)
			Usual Residence of Decedent		99				October	28, 1909		Maryland
	/lanc		10a. State 10b. County	1	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	Mar 1-f st	ģ	Maryland Mo	ontgomery			I	Bethesda				1 ☐Yes 2 No
	r 286	ire	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	h with	a D	7420 Westlake 3	errace. #60	7			20817			U.S.A	
	items	<b>Funeral Director</b>	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No	- 14. R	ace - Americ	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, if a Michal Evaning routher than a longer than the mouth of a longer than the mouth of a longer than the mouth of a longer than the mouth of a longer than the mouth of a longer than the mouth of a longer than the longer th		1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorce	If Yes Gi	2 X No ive		lf Yes, specify Cuba 1 □Yes 2⊠ No	an, Mexican, Puert Specify:	o Rican, etc.)	Spec	ack, White, o	etc. White
ŏ	2 hot	Completed by	15. Decede	nt's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/Inc	
75	in 7; in "n	ble	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (		(Give	kind of work done o	during most of wor. I)	king			,
21	i with	E	Liementary/Secondary (0-12)	College (	,	A	ssistant Pi	cincipal		D.C.	Public	: Schools
b	othe /ent,	O)	17. Father's Name (First, Middle	Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surna	ame)	
<u>a</u>	should be f and Mental   s marked oi umatic eve	To B		Samuel Tos:	sman				Fannie	Baranosk	y	
ary	shou and h	-	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numb	er, City or Tow	n, State, Zip	Code)
Σ	and 2 ealth a m 27 is		Peggy Hirsch -	Daughter		7420	Westlake I	Gerrace, #4	07. Bethe	sda. Mar	vland 2	0817
re.			20a. Method of Disposition			Place of Dispo	sition (Name of natory or other plac		Date	20c. Location		
E	Page ient nnt:# ryor		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$		State		n Cemetery		/01 /0000	A 4 - 1 - 1-	. V	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service	* **	FIL		. Name and Addres		01/2009	Adelph	i, Mary	Tano
ä	Pe in Fig		) alop	wom	و00	H	ines-Rinald	li Funeral	Home, Inc	Nor Spri	na Mar	yland 20904
			23a. Part 1. Enter the diseas shock, or heart failure. Lis	complications that o	caused the deat						ng. nai	Approximate Interval Between
	Physician		immediate Cause (Final disease or condition		spiration							Onset and Death
	/Medical		resulting in death)		(or as a conseq		ııa				_	6 hours
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39			IF FEMALE;									
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0.	e des he el hed fo	sici	1 ☐ Yes 2 🖾 No		nant at time of c		Other (specify)			N	fonth	Day Year
<u>٦</u>	that the de ned by the detached	h	9 Unknown						-			
Ś	signed signed d be det	by	Part II. Other significant conditi			ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use cor	ntribute to th	e cause of death?
ord	w requir s been s should	ted	Cerebra	1 Meningioma	3				1 🗆 1	res 2⊠ No	3 ☐ Prob	ably 4 ☐ Unknown
Vital Records,	blaw r has be	Completed							24a. Was		. Were autor	psy findings available
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<u>it</u> a	stor,	Be (	25. Was case referred to medica examiner?					26. Place of Deal			11162	2 🗆 140
of	Physician: this certific ral director, I	10E	1 Yes 2 No	Hospital: 1 □	Inpatient 2	ER/Outpatien	t 3 □ DOA Othe	er: 4 🗆 Nursing He	ome 5 🖺 Resid	dence 6 □ O	ther (Specifi	/)
		Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date	of Injury oth, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h			/
<u>Ö</u>	Attending or deeth. ector: Afte by the fune	atic	2 ☐ Accident investi	gation	,,,	,,		res 2 □No				
<u>   </u>	r Attributed of the control of the c	iii	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ained 28e. Place	of Injury - At ho	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Num	ber or Rura	Route Number,
-Division	ital or irs afte ral Dir led in	Certification:		23110	J (Specif,			-	Only of TOW	m, otale)		
	To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 ☑ Certifyli (Check only one) 2 ☐ Medical	ng <b>Physician:</b> To the <b>Examiner:</b> On the b and man	best of my kno pasis of examina oner stated	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occur	, and due to the rred at the time,	cause(s) and n date and place	nanner as st , and due to	tated. the cause(s)
	Vithius Compared to the compar	Ž	29b. Signature and title of certifie	1		-	29c. License	number		29d. Date sign	ed (Month, L	Day, Year)
	20		1/2/1/	wor	cy	Vali	I	030844		0210	52/	P. 200 C
	•		30. Name and address of person	who completed caus	se of death (Item	23a) (Type, T				-/-	-/	200 /
			James F. McMurr	ay, Jr., M.I	D., 11119	Rockvil	,	ite 409, R	ockville,	Maryland	20852	
	Sta		31. Date filed (Month, Day, Year)	32 B	Registrar's Signa	ture				-		
	Registr	ar	FEB 03	2009 Cen	ion &	. Man	W.					

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

### State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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burial-tran Box 68760. P.0. of Vital Records. Division

Baltimore, Maryland 21215-0036

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 29, 2009 Roberta J. McVeigh 10:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min 364-22-6462 Director 86 Feb. 24,1922 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Montgomery Gaithersburg 1 X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a 20877 15 Maryland Avenue United States Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐Yes 2 No ģ Specify Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Administrative Assistant Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milo Hulliberger Grace Durham 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick E. McVeigh (Son) 15 Maryland Avenue, Gaithersburg, MD 20877 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State January 30, Department of Important: If it any injury or o 1 ☐ Buriai 2 🙀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2009 Alexandria, Virginia Crematory 21. Signature of Funeral Service Licent 22. Name and Address of Facility DeVol Funeral Home, E.K uetis 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pleural Effusions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Fundarian Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burn Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? ₽ Right Hip Replacement 12/08; Type II Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☑No 2 KINO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0065485 Supunich, PSM UID 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Ann Supanich, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year, Registrar's Signature State FEB 03

DHMH 17 Rev 1/2001

Registrar

			1 - State Registrar	State of Mar		epartment of F Certificate of			iene •g. No 2 0 0 9	01810
	Physici		1. Decedent's Name (First, Middle, Las	McCross				2. Date of Deat Month	th Day Yeer	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give Brocke Crowe Rebrashili ) at	street and number)		4b. City, Town, of Sandy	Son?		4c. County of Dea	meny
	Funeral Director		5. Social Security Number 6. Sec. 578-44-5224 1. Usual Residence of Decedent	7. Age (i	In yrs. last birtho	Months Days	Hours M		Year) C	rthplace (State or Foreign ountry) RYLAND
	thould be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other then "netural", or items 23a or 28e-f ehow matte event, the Madical Examiner was be notified at	Funeral Director	10a. State 10b. County  Maryland Howard  10e. Street and Number  13274 Clarksvil.  11. Marital Status	le Pike	Oc. City, Town of High	land 10f. Zip Code	20777	U	0g. Citizen of What C Inited Stai	tes of Americ
-0036	Phours after of stural, or iter	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub  1 ☐ Yes 2 ☑ No ecedent's Usual Occur	Specify:		Black, Whi	te, etc. Aucasian
Maryland 21215-0036	filed within 72 Hygiene. other then "nel	Completed	(Specify only highest grade Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last)	de completed)  College (1-4or 5+)	((	ive kind of work done e. DO NOT use retire  None	during most of v	rorking		
aryland	2 should be f and Mental h le marked of eumatic eve	To Be	Leonard L. McC1  19a. Informant's Name/Relationship (7)		19b. N	ailing Address (Street	Mary	ame (First, Middle, M Virginia Rural Route Number,	Johnson	Zip Code)
_	7 1 7 1 tre		Patricia Storch -  20a. Method of Disposition  1 Burial 2 Cremation 3 D	Removal from State	A 345 20b. Place of D cemetery,	4-102 Ellis sposition (Name of crematory or other place	cot Cent	Date Drive;	Ellicott 20c. Location - City or	City MD 2104 Town, State
Baltimore,	permit. Pages 1 and Department of Healt Important: If itsm 2 any injury or other 2009.		*4 □ Donation *5 □ Other (Specify  21. Signature of Funeral Service License			oln Cremato 22. Name and Addre 1040 Rockv	ss of Facility S	imple Trib	ute Funera	1 & Crematio
8/60,	The death certificate be executed by the attending physician and the attending physician and the attending physician and the attending the att	dical Examiner	23a. Part1. Enter the disease, or compositors, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CO PON  Due to (or as a c  Due to (or as a c  Due to (or as a c	consequence of)	enter the mode of dying ARRITY ARREPT	THM IA	ac or respiratory arre	est,	Approximate Interval Between Onset and Death MIDUTES
O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetel death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of de Month	livery Day Year
Records, P	The law requires that ite has been signed b page 2 should be deta	þ	Part II. Other significent conditions co	ntributing to death but n	not resulting in th	e underlying cause giv	en in Part I.	23e. Did tob	eacco use contribute to	o the cause of death?
Vital Rec		Be Completed	25. Was case referred to medical examiner?				26. Place of D	24a. Was ar autops perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
0	Physical Phy	ို	1 Yes 2 No	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpa		4 Nursing	Home 5 Reside	nce 6 Other (Spe	cify)
DIVISION	of or Attending Falter death. I Director: After d in by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Yo	ear) Inju	y Wor	k? Yes 2 □ No		reet and Number or Ri	ural Route Number,
>	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	Medical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exemi	rsician: To the best of n iner: On the basis of ex and manner stated	camination and/o	eath occurred at the tir r investigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)
)	To t withi To th	W	29b. Signature and title of certifier  THY AT  30. Name and address of person who co	an. M.D. 18	100 Sky	29c. Licens Dy De, Print)	2046	Sandy S	Sping M	1. Day, Year) 1. (6, 2009 20860 ay kind
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	greatile .			em 23at	er M	arylan	A/ <b>, 85/2</b> Cei	tificat	e of L	ealth Death	angd <sub>1</sub> N			ene <sub>g. No.</sub> 20	009 (	04811	
Physicia	ın	1. Decedent's Nam  Arlen	ne (First, Middle Le Kauf		rlow	e						2. Date of Month		Day 1, 2	Year	3. Time <i>o</i>	
/Medica Examine		4a. Facility Name (								Location o			lary	4c. Coun	ty of Death		<b>P</b> • <sup>M</sup>
Funeral Director		5. Social Security 1 578–88–6	475	6. Sex 1 □ M 2 🗶		e (In yrs. 49	last birthday) Yrs.	If Under Months	r 1 Year Days	If Under Hours	Min.	8. Date o (Month <b>April</b>	n. Day.	Year) 1959	Cou	place (State intry) ington	
land 5w		Usual Residence of 10a. State	10b. County			10c. Cit	y, Town or Lo	cation								10d. Inside C	ity Limits
Mary	ţċ	MD	Monts	gomery		Bet	thesda									1 <b>K</b> Yes	2 🗆 No
or 28	Director	10e. Street and Nu	ımber			1		10f. Zip	Code				10	g. Citizen o	f What Cou	ntry?	
ath w	ral	6909 Nev	vis Road						0817					USA			
irs a	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Mari</li><li>3 ☐ Widowed</li></ul>		ried 1 📑	Decedent of Forces? (es 2 4) s, Give or Dates:	Ever in U. No	1	Vas Deced fYes, sped I∐Yes		spanic Ori n, Mexicar Specify:		ecify Yes o Rican, etc.	r No- .)		ace - Ameri lack, White, cify: <b>Wh</b>		
72 hor	eted	(Sne	15. Deceden	t's Education st grade comple	ted)		16a. Dece	dent's Usu	al Occupa	ation	t of work	ina	10	6b. Kind of	Business/Ir	ndustry	
ithin ne.	Completed	Elementary/Sec	ondary (0-12)		ge (1-4or 5	5+)	Homen			furing mos. )	t or work	mg		0	Home		
illed w Hygie ther t		12 yea		Last)			пошев	акег		18 Mothe	er's Nam	e (First, Mid	ddle Ma				
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nd 2 sho alth and 27 is m r traum		19a. Informant's N Shirley					1					ral Route No esda,		-	n, State, Zi	p Code)	
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permit. Departm importa any inju		21. Signature of F	uneral Service		dvr		22	. Name ar	nd Addres	s of Facilit	y Edv	vard S	age	1 Fun	eral	Direct 20852	
Physician /Medical Examiner	Examiner	23a. Part 1. Enter shock, or he Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease o	art failure. List (Final on )	a	on each III	ous (	Cell Ca		1	Mand1	pre	or respirato	ory arres	st,		Approxima Interval Be Onset and <b>mont</b>	tween Death
eath certificate be attending physicis for use as the bur	hysician/Medical Exan	that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1 □Yes 2	Last  nt pregnant 2 months?	23c. If yes	e to (or as	of pregna	ancy	Ectopic p		,					Date of deliv	-	Year
w requires that the d	by Phys	9 Unknowi	n Ificant condition	ons contributing			ulting in the ur	nderlying c	ause give	en in Part I.		23e. [	Did toba	acco use co	ntribute to	the cause of	death?
equire een si ould b		Persiste	ent veg	etative	Stat	e						1	I ☐ Yes	2X No	3 Pro	bably 4 🗌	Unknown
n: The law i ficate has b r, page 2 sh	Completed											а	Was an autopsy performe es 2		prior to co death?	opsy findings ompletion of o	available cause of
rsicia s certi	D Be	25. Was case refe examiner?		Hospital:	1 🗆 Innatio	ent 2 🗆	ER/Outpatier	* 3 \( \tau \)	Othe			h <i>(Ch</i> eck o <i>i</i> ome 5 □ F			Mh / (2		
g Phy ter thi neral o	n: To	27. Manner of Dea	ith		Date of Inju	ıry	28b. Time of Injury		28c. Injury Work		Jisilig He	28d. Descr	ribe how	injury occi	urred Sul	ject o ith a	lrive
endir eath. or: Af	Certification:	1 Natural 2 X Accident	5 ☐ Pendin investig 6 ☐ Could	gation 08/	22/19	992	4:47	<b>P</b> • M	1 🗆 ነ	res 2X	No	or a c	ear 1s e	colll jecte	dea w d.	ith a	car
or Att	ŧ	3 ☐ Suicide 4 ☐ Homicide	determ	nined 20e. F	Place of Injouilding, et	ury - At ho c. <i>(Specif</i>	ome, farm, str	eet, factory	y, office			28f. Location City or	on (Stre r Town,	et and Nur State) <b>S L</b>	nberorRui <b>ate R</b>	oad 20 ana, De	nber, "near
	ledical Ce	29a. Certifier (Check only	1☐ Certifyir 2 <b>X</b> Medical	ng Physician: T Examiner: On	the basis o	of my kno	wiedge, deati	n occurred	at the tin	ne, date ar pini <i>o</i> n, dea	nd place,	and due to	the car	use(s) and	manner as	stated.	
o the ithin 2 o the omple	Med	оле) 29b. Signature and	title of certifie	_ /	mathnér st	ated.		290	c. License	number			200	d. Date sign	ned (Month	Day, Year)	
F \$ F 5		•	1/	11 X	m				O.C.1						2009		
	-	30. Name and	dress of person	who completed	cause of c	leath (Iten	n 23a) (Type,	Print)						-,,			
				ple, M.I	)	1	11 Per	n St	reet,	Bal	timo	re, M	ary]	Land 2	21201		
Stat Registra		31. Date filed (Mo	nth, Day, Year) Y <b>2 1 20</b>	09 8	32. Registr	ar's Signa	fare										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State
Registra/NFND#23a(b)+29dperND1,2/4/09,BMW,MCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 30, Elianne Marthe Mabie 2009 1:30 p M /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 3, 19 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 219-64-4923 79 1929 Director France Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrailirating be prefilled at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Olnev 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18512 Bowie Mill Road 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: \$ Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcel Jouen Christiane Lemeur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Mabie/Husband 18512 Bowie Mill Road, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2009 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd., W,. Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepols /Medical Due to ras a consequence of): Examiner Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OVED BY MEDICAL EXAM re to (or as a ounsequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, attending physician a for use as the burial-CERTIFICA Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown has been si e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient this 2 ER/Outpatient 3 DOA Yo the Hospital or Attending Phys
within 24 hours after death.
To the Funeral Director: After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 10 D24190 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) 3416 Olandward Court Olney Woodward JR 31. Date filed (Month, Day, Year) State Registrar

				partment of Health and I	Mental Hygie	ne	01010
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.	No.2009	3. Time of Death
	Physici		Helen Spalding Mattingly		Month	Day Year 3. 2009	M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	February	3, 2009 4c. County of Death	7:30 p ™
apart !			41675 Mattingly Street	Leonardtown		St. Mary'	S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	9. Birthr	place (State or Foreign
	Director		Usual Residence of Decedent		03/12/19:	32 Mary	land
	ryland how	_	10a. State 10b. County 10c. City, Town or	Location		1	IOd. Inside City Limits
	8a-f s	Director	Maryland St. Mary's Leonardto	own			1XYes 2□No
	with the		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	eath v	Funeral	41675 Mattingly Street  11. Marital Status  12. Was Decedent Ever in U.S.  1	20650	U1	nited Stat	
0	r iten	Fun	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
5-0036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show diest Examiner must be mulffied at	d by	3 🕅 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐Yes 2 X No Specify:		Specify: Wh	nite
ה	72 he "natu	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ing 16b	. Kind of Business/Inc	
7	within ene. than	d mc	College (1-40r 5+)			_	
מ	filed I Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	stered Nurse 18. Mother's Nam	e (First, Middle, Maid	ursing den Surname)	
land	Jild be Jenta rked tlc ev	To B	Francis Xavier Spalding	Elizabet	h Thompson	1	
ar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Pedical Examiner must be profitted at once.			ailing Address (Street and Number or Ru			Code)
e, e	and tealth m 27		Deborah Zylak/Daughter P.O.	Box 52, Leonardto			
	ages 1 nt of H : If ite			sposition (Name of crematory or other place)	Date 20c	. Location - City or To	wn, State
Saltimor	artme artme ortant Injury		4 □ Donation 5 □ Other (Specify) Matting 1  21 Signature Funeral Service Licensee	y Family Cem. 02/0	•		
Ö	Dep Imp any		Vellage ( 14 / )	Br	insfield H	Tuneral Hor	ne, P.A.
			23a, Part 1, Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arrest,	dtown, MD	Approximate
and a	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	14			Interval Between Onset and Death
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	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
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00	ertifice ling ph e as th	Med	IF FEMALE:				
Š	ath co	hysician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delive	ory Day Year
j	the de	ysic	1 ☐ Yes 2 ဩNo 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		inotal i	Day .ca.
ī.	that ned b	Δ.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
cords,	quires	ed by	intra Ganial bleed		1 ☐ Yes	2∏No 3☐ Prob	ably 4 ☐ Unknown
ב כ	law re as bee 2 sho	plet			24a. Was an	24b. Were autor	psy findings available
=	The cate h	Completed			autopsy performed 1 □ Yes 2 □	?   death?	npletion of cause of 2 □ No
ב	Iclan: Sertific Sector,	Be (	25. Was case referred to medical examiner?		h (Check only one)		
5	Physical din	<u>د</u>	1			e 6 ☐ Other (Specify	)
5	th. th. tree	tion	1 Natural 5 Pending (Month, Day, Year) Injur		28d. Describe how in	ijury occurred	
2	Atter er dea ector by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rural	Route Number,
5	ital or rs afte al Dir led in	Cert	4 ☐ Homicide building, etc. (Specify)		City or Town, St	ate)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Attenthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, de (Check only one)  2 Medical Examiner: On the basis of examination and/one and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	Fo the vithin Fo the comple	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
)			Mr. attending	0005568		2/4/1	59
			20 Name and Address of Secretary and Address of Address of Secretary and Address of Secretary an	e, Print)	inni cil A	10 000	0/50
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	Registra		FEB 6 2009 Januar B.	whit			į

			1 - For State Registrar	ate of Maryland		artment of F		nd Mental	Hygien Reg. N	201	9	04814
			Decedent's Name (First, Middle, Last)					2. Date o	f Death	·		3. Time of Death
	Physici /Medio		Joyce A. McMillan					Jan.	30	) 2	009	15:45 P™
1	Examir		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of	Death	4	c. County of	Death	
			Sunbridge Care & Re			E1kt					ci1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)  3 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month	ı. Day, Yea	1025	9. Birthp	lace (State or Foreign stry)
	Director	ļ	Usual Residence of Decedent	/	3 '''			Feb.	12,	1935	V1	rginia
	yland now		10a. State 10b. County	10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	a-f sl	ctor	Maryland Cecil		E1kt	on						1XYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. 0	Citizen of Wh	at Coun	try?
	s 23a	ral	1 Price Dr.			219:				USA		
	er de	Funeral	11. Marital Status	as Decedent Ever in U.S. med Forces? ☐Yes 2XXNo	13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Orig an, Mexican,	in? (Specify Yes o Puerto Rican, etc.	r No- )	14. Race - Black,	- Americ White, 6	
36	Ir, or		If	Yes, Give ear or Dates:		□Yes 2XNo	Specify:			Specify:	Wh	ite
9-	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Examinat must be notified at	Completed by	15. Decedent's Education		16a. Deced	lent's Usual Occup	ation		16b.	Kind of Busi	ness/Inc	dustry
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pur	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)					's Name (First, Mi		en Surname)	)	
ΣŽ	hould d Mei marke matic	은	John Allison  19a. Informant's Name/Relationship (Type. P	rime)	40h Mailia	g Address (Street		ell Mars				2.71
Ma	d2s Ith an 27 is :		Michael D. McMilla	· .		uth Fawn				.9711	іате, ∠ір	Code)
ē,	f Hea f Hea ltem other		20a. Method of Disposition			sition (Name of natory or other place	7 1	Date	20c.	Location - C	ity or To	wn, State
E O	Page: nent o nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai irom state i		ingham C	· U	2-04-200 v	9 Cc	lora,	Mar	vland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra <u>once</u> .		21. Signature of Funeral Service Licensee			Name and Addres						<i>y</i>
<u>m</u>	8 8 E 6 8		1			111 S. Q	ueen S	St., Risi	ng Su	in, MD	21	911
		SALES.	23a. P Enter the disease, or complication hock, or heart follure. List only one can	ns the caused the death.	Do not ent	er the mode of dyin	ng, such as c	ardiac or respirato	ry arrest,			Approximate Interval Between
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D)	/Medical Examiner		resulting in death)	Due to (or as a consequent		05						
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,	PIDEMIA						
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Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnanc Live birth 2 Fetal de	eath 3	Ectopic pregnanc	у			23d. Date Mont		ry Day Year
P.O.	at the de by the a stached	Physician/Me		☐ Pregnant at time of dea ☐ Unknown	tn 5∟	Other (specify) _			-			
σ,	iires that i signed by d be detai		Part II. Other significant conditions contribute	ing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.	23e. I	Oid tobacco	use contrib	ute to th	e cause of death?
of Vital Records,	quires an sign uld be	Completed by	DEMENT	14					□Yes	2	☐ Prob	abły 4 Unknown
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) t	Physic this o	은	1 ☐ Yes 2 No Hospit	1 Inpatient 2 E			4 Jai Nur	sing Home 5 🗆 I	Residence	6 ☐ Other	(Specify	v)
n C	ing F	ion:	7	a. Date of Injury (Month, Day, Year)	Bb. Time of Injury	Work			ibe how inj	ury occurred		
Division	death death ctor: y the	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28	e. Place of Injury - At home	e farm stre		Yes 2□N		on (Street	and Number	or Pura	l Route Number,
Ρ	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	o, iaiii, ou	ot, laoto j, onice		City o	Town, Sta	ite)	Oi nuia	noute trumber,
	ospita hours ineral		29a. Certifier 1 Certifying Physician	: To the best of my knowle	edge, death	occurred at the tir	ne, date and	d place, and due to	the cause	(s) and man	ner as s	tated.
	the Holin 24 the Fu	Medical	(Check only 2 Medical Examiner: one)	On the basis of examination manner stated.	n and/or in	vestigation, in my o	pinion, deatl	h occurred at the t	me, date a	.nd place, an	d due to	the cause(s)
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Σ	29b. Signature and title of certifier	0		29c. Licens			29d. E	ate signed (		Day, Year)
			b. n. Nonder				0657	3.5		2/2	109	
	5		30. Name and address of person who comple	ted cause of death (Item 2	3a) (Type,	Print)	219	o 1				
	Sta	nte.	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e /	12 , 11 D	417	<u>. '</u>				
	Regist	rar	126 A F 141GH S 31. Date filed (Month, Day, Year) FEB 0 3 2009	lener B.	your							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 ( Amended. #17. TCH begistrar 02/05/2009. TLS -#18 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7:35 PM RUTH U. MULLIKIN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easto Talbot HOSPITA Easton Membrial If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🛣 Days Hours Min MAR 4, 1926 GERMANY 82 Director 220-28-1595 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show It e Modical Expanier must be notified at EASTON 1 X Yes 2 □ No TALBOT Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 702 WAYSIDE AVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status illed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK GROCERY STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN Else Behnke <del>(UNKNOWN)</del> MACEDOWSKI Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If Item 27 Is any injury or other trau LINDA CHEEZUM/DAUGHTER 611 WINDMILL ROAD, EASTON, MD 21601 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 2/3/2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHO MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specity) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe page 2 1 HO 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29c. License number

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

DENNIS M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

DESHIELDS M.D. 219 S. WASHINGTON ST., EASTON, MD 21601

1)00531

29d, Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Marylan			Health and M	lental Hy	giene	00 01 01
			1 - State Registrar		Cei	tificate of	Death		Reg. No. 2 U	09 04816
	Physici	ian	1. Decedent's Name (First, Middle, Last)					<ol><li>Date of De Month</li></ol>	_	3. Time of Death
	/Medi	cal	BARBARA M. MESSICK					Januar	009 0205 M	
	Examir	ner	4a. Facility Name (If not institution, give street and num	ber)			r Location of Death		4c. County of	1 7
	Funeral		Memorial Hospital  5. Social Security Number 6. Sex 7	7. Age (In yrs.	last birthday)	Eas If Under 1 Year		8 Date of Bir	,	9. Birthplace (State or Foreign
	Director		142-12-2511	86	Yrs.	Months Days	Hours Min.	(Month, Da	th ay, Year) 30.1922	Country) VIRGINIA
	pt ,		Usual Residence of Decedent							VIRGINIA
	arylaı show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	with the Maryland a or 28a-f show	Director	MD TALBOT		EA	STON				1X Yes 2 □ No
	with t	١	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	ous after death with the Maryland ral", or items 23a or 28a-f show Examine must be notified at	Funeral	311 OAK AVE.  11. Marital Status 12. Was Deced	lent Ever in II	S 113 V		21601	oifu Vos or No		USA
တ	ы <b>ў</b>	큔	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2	2057			lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black	- American Indian, , White, etc.
₹ 50	al", o	5	3 👿 Widowed 4 🗆 Divorced If Ƴes, Give Year or Dat	9	1	□Yes 2 <b>▼</b> No	Specify:		Specify:	WHITE
essick 21215-0036	172 hours after "natural", or ite	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	ent's Usual Occup	ation	200	16b. Kind of Bus	iness/Industry
55	/ithin ine. <b>han</b> "	ם	Elementary/Secondary (0-12) College (1-4	for 5+)	life. L	O NOT use retired	during most of workii d)	<i>'9</i>		
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and	d be f ental l sed or	Be C	JAMES F. BEACHAM				18. Mother's Name			)
$^{\alpha}$ $^{\beta}$ $^{\lambda}$ Maryland	should bd Me mark mati	ည	19a. Informant's Name/Relationship (Type. Print)		19h Mailin	a Address (Street	SALI and Number or Rura	Y BOOT		T. O. I.
	alth at 27 is rtrau		BARBARA D. MITCHELL/DAUGH	idir.d						
ਤੂ <b>e</b>	s 1 ar of Hea item		20a. Method of Disposition	20b. P	lace of Dispos	ition (Name of	DE SPRINGS	ate DR. D	20c. Location - C	D 21629 lity or Town, State
Barbara Baltimore, N	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, It e Manical once.		X Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)			MEMORTAI	L PARK 2/4	1/2009		MARYLAND
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- W	permi Depar Impo any Ir		JOHN R. MER	CFRE	$\sim$ F	ELLOWS, I	ELFENBEIN	& NEW	NAM FUNE	RAL HOME PA
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	Physician		Immediate Cause (Final disease or condition	cval 1	alsov	meun	~40.4			Onset and Death
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	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	r as a consequ	uence of):					
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Box	or Attending Physician: The law requires that the death certificatifier death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco						23d. Date	of delivery
	deatl	icia	in the past 12 months?	th 2□Fetal int at time of de		Ectopic pregnancy Other (specify)	<u> </u>		Mont	
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ţ,	ding Physician: The law n. After this certificate has funeral director, page 2 s	ို	1 ☐ Yes 3 ₹ No Hospital: 1 ₹ Inp 27. Manner of Death 28a. Date of	patient 2 2			4 LI Nursing Horr		ence 6 ☐ Other	
Division of Vital Records,	ding h. After funer	Certification:	1 Natural 5 Pending (Month,	Day, Year)	28b. Time of Injury	28c. Injury Work	rat ? Yes 2 □No	8d. Describe h	ow injury occurred	
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	pspita hours inera y fille		29a. Certifier Certifying Physician: To the be	est of my knov	wledge, death	occurred at the tim	ne, date and place, a	nd due to the o	cause(s) and man	ner as stated.
	he Hc in 24 he Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basi and manner	is of examinat	tion and/or inv	estigation, in my op	pinion, death occurre	d at the time, o	date and place, an	d due to the cause(s)
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (	Month, Day, Year)
	TLS		1 sent sul m			PØ\$5	59762		129/0	29
	12+VA		30. Name and address of person who completed cause of	of death (Item	23a) (Type, P	rint)	-001 C	1601	21954	Jashingtonst.
			31. Date filed (Month, Day, Year) 32. Reg	M)	Ura	-0 stal	1111/	100		<u> </u>
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# Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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		For State		State of Ma	aryland		irtment of <i>tificate o</i>	Health and	Mental Hy		000	0 01	
		Registrar  1. Decedent's Name (#	First, Middle, Last)			Cer	illicate o	Dealli	2. Date of D	Reg. No eath	200	3. Time o	8 7
Physicia /Medic		META MAR	RGUERITE	McMAHAN					Month FEBRUA	RY 1		7:45	<b>AM</b> <sup>M</sup>
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Director		217-01-940	J4	M X F	90	Yrs.	Months Day	s Hours Min.	(Month, D	ay, Year)	_   0	ountry) ARYLAND	
and w		Usual Residence of De 10a. State 10	ecedent 0b. County		10c. City, 7	Town or Lo	cation					10d. Inside C	ity Limits
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permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, I'm Medical Event once.	၉	19a. Informant's Name	RION WILL			19h Mailin	a Address (Stre	eet and Number or R	WARNER	her City o	or Town State	Zin Codo)	
and 2 s ealth ar n 27 is ner trau		JANET M. F						ROAD, BL					6561
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t. Pag rtment rtant:		4☐Donation 5	Other (Specify)		JUN			METARY 02	/04/09	PR	ESTON,	MD	
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The cate hat page	Completed	Clin	mie Ol	3 huch	rue h	ring	Deseu	se	auto perf 1 □ Yes	opsy ormed? 2 No	death?	completion of c s 2 □ No	ause of
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3		30. Name and address	THE WOOD	TD W	<sub>D</sub> 5	OI DU	TCHMANS	LANE, EA	STON. M	D 214	501		
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			Registrar  1. Decedent's Name (First, Middle, Last)		Cer			2	. Date of Deat		009	3. Time of Death	
	Physici /Medio		Loyd Bernard MEIER						Month Februar	y 3,	2009	11:34 p. <sup>M</sup>	
	Examin	ier	4a. Facility Name (If not institution, give street and number)	704		4b. City, Town, or		of Death			inty of Death		
	Funeral		11215 Youngstoun Dr., Apt.  5. Social Security Number 6. Sex 7. Age	/ U4 e (In yrs. last	birthday)	Hagers If Under 1 Year	If Under		. Date of Birth		ashingt 9. Birthi	place (State or Foreign	
П	Director		506-42-0631 1™ 2□F 8	31	Yrs.	Months Days	Hours	Min.	(Month, Day, ay 13,	1927	Nebi	raska	
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	a-f sh	ctor	Maryland Washington		На	agerstown			1 ☐ Yes 2 🔀 No				
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2	filed with Hygiene other tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+	.,	plum	ber				plumb	ing co	ntractor	
Maryland	O m >	a	17. Father's Name (First, Middle, Last)  Richard Meier						First, Middle, N teffen	laiden Surn	name)		
ary		ဥ	19a. Informant's Name/Relationship (Type. Print)	1	19b. Mailin	g Address (Street a				City or Tov	wn, State, Zir	Code)	
	tra tra		Jene Lee Meier - wife		11215	Youngsto	oun D	r., Ap	pt. 704	, Hag	erstow	m, Md.21742	
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ceme	etery, crem	ition (Name of atory or other place		Date			on - City or To		
<u>=</u>	nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Kose		Cemetery Name and Addres		2/9/0	1		sburg,	, WV	
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	ertifical	Medi	IF FEMALE:										
Box	w requires that the death certifice been signed by the attending ishould be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal dea	ath 3 🗆	Ectopic pregnancy				1	23d. Date of delivery Month Day Year		
	the de sy the	hysic	1   Yes 2   No 9   Unknown	ime or deair	1 5	Other (specify)							
S,	requires that the	by P	Part II. Other significant conditions contributing to death but	not resulting	g in the un	derlying cause give	n in Part I.		23e. Did tob	acco use co	ontribute to th	ne cause of death?	
<u>6</u>	requir bould	sted							1 □ Ye:	s 2∐No	3 ☐ Prob	ably 4 🗌 Unknown	
Records,	: The law cate has t page 2 sl	Completed							24a. Was an autopsy perform	ed? 24	b. Were autor prior to cor death?	psy findings available mpletion of cause of	
		Be Co	25. Was case referred to medical				26 Place	of Death (C	1 ☐ Yes 2 Check only one	□No	1 ☐ Yes	2 □ No	
o +	Physician: this certific ral director,	일	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien	it 2 □ ER/	Outpatient	3 ☐ DOA Othe	F1	,	5 1 Resider		Other (Specifi	y)	
_	ng ffe	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day,	year) 28b	D. Time of Injury	28c. Injury Work? M 1 🗆 Y			. Describe how	v injury occ	urred		
UIVISION	Attending r death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injur	y - At home,	farm, stree		′es 2□N		Location (Str	eet and Nui	mber or Rura	I Route Number.	
5	Itai or rs afte al Dir	Cert	4 ☐ Homicide determined building, etc.	(Specify)					City or Town,	State)			
	To the Hospitai or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of € and manner state	examination	dge, death and/or inve	occurred at the timestigation, in my op	e, date and pinion, deat	d place, and th occurred	due to the ca at the time, da	use(s) and te and plac	manner as stee, and due to	tated. the cause(s)	
	To the within To the comple	Mec	29b. Signature and title of certifier	au.	<u></u>	29c. License	number		29	d. Date sigi	ned (Month, L	Day, Year)	
			Michael Mulm	el	MA	0	4 16	67		2.	.4.0	9	
4	H-8		30. Name and address of person who completed cause of dea	ath (Item 23a	a) (Type, P	rint)	0	10	1 /		11	colom MO	
امد	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar	mect 's Signature	/1	1110	/ Me v	1(22)	(0	nyc.	1 (03)	colom mo	
	Registra		FEB 0 5 2009	and a	1. 1	atel							

			Please	Type or Print	in Bl	ack Ir	ndelible	Ink.	Ensure A	II Copies	s Are	Legible.		
			For	State of Mai	ryland					Mental Hy	/gien	е		
			State Registrar			Ce	rtificate	of D	eath	1	Reg. No	2009	0481	9
	Physici	an	Decedent's Name (First, Middle, Last     Dennis Mic						2. Date of D	Day Year				
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, To	own, or L	ocation of Death	Feb.	7	2009 c. County of Dea	12:30 A	IVI	
)	Examin		254 Victory Post Drive				Weste					Allegany		
Funeral 5. Social Security Number 6. Sex 7. Age (In 212-54-8106 1 № M 2 ☐ F 5.7							if Under 1 Months		If Under 24 Hrs. Hours Min.	8. Date of Bi	irth	9. Bir	thplace (State or Fore	∍ign
	Director		212-54-8106 <sup>1</sup> Usual Residence of Decedent	x <sup>M</sup> <sup>2□</sup> F 57		Yrs.				03-14-	-195		vser, WV	
	yland iow at		10a. State 10b. County			Town or L							10d. Inside City Lim	nits
	a-f sh	ctor	MD Allega	ny	west	ernp	ort				1 □ Yes 2 🔀	No		
	or 28	Director	10e. Street and Number	Destant			10f. Zip C		•		10g. Citizen of What Country?			
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show If then Z1 is marked other than "natural", or items 23a or 28a-f show If other traumatic event, the Medical Examiner must be notified at		254 Victory Post	12. Was Decedent Ev	or in IIS	10	2156		ania Origin? /Sr	agifu Van ar N	US	A 14. Race - Ame	nion Indian	
· _	r Item	Funeral	11. Marital Status  1   Never Married 2   Married	Armed Forces? 1 ☐ Yes 2 1 No		. 13.			panic Origin? (Sp Mexican, Puert	Rican, etc.)	0-	Black, Whi	te, etc.	
036	rai", o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	<b>⊠</b> No	Specify:			Specify: WI	HITE	
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	İ	(Giv	edent's Usual e kind of work	done dui	on ring most of wor	king	16b. k	. Kind of Business/Industry		
121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	)		ber Cut	,			Lu	umber		
q 7	filed w Hygier other the	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden S											
<u>lan</u>	should be f and Mental I s marked of umatic eve	To B	Edward Michael		,	Jerry Wl	niteman							
Baltimore, Maryland 21215-0036	12 should be filed w n and Mental Hygie r Is marked other th raumatic event, th	-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z.									Zip Code)		
2`	1 and 2 Health tem 27 i		Jerry Michael	(MOTHER)	COL DI-				st Drive			rt, MD		
סב	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cer	metery, cre	osition (Name ematory or oth rial Va	ner place)		Date 0-2009	PO PO	ocation - City or BOX 9128	Town, State	
ᄩ			4☐Ponation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				22. Name and		1			_	, WV 26506	
Ba	permit. Departr importa any inju		Bolet 11	Bolward	/				ift Reg	istry M	orga	ntown, 1	v v 5506	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	he death.	Do not er	nter the mode	of dying,	such as cardiac	or respiratory	arrest,		Approximate	
-	Physician		Immediate Cause (Final disease or condition	META		TIC	250	PH	AG-EA	LOF	INC	INDON+1	Onset and Death	1
À	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):							AW9200	6
4		-B	Sequentially list conditions,	b Due to (or as a	conseque	ence of:					'			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,									
60,	be executed ician and burial-transit													
-		Physician/Medical		d										
Box 687	certific ding p	/Med	IF FEMALE: 230 If you guitoome of programmy											
	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)  Month							livery Day Year			
P.O.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
S,	The law requires that the death certificate the has been signed by the attending physings 2 should be detached for use as the	by P	Part II. Other significant conditions of	eart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								co use contribute to the cause of death?		
ord	requir									1 🖸	Yes 2	2 □ No 3 □ P	robably 4 □Unkno	wn
Vital Records,	e 2 sh	Completed								24a. Was	ppsy	prior to	utopsy findings availal completion of cause of	ble of
a										1□ Yes	ormed? 2 N	o death? o 1 ☐ Yes	2 <b>⊘</b> No	
	rsicia s certii irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	2 🗆	D/Outpatic	ent 3 DOA	Othor	26. Place of Dea			. To: (0		
Division or	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	. 2	28b. Time		c. Injury a Work?		28d. Describe		6 ☐Other (Spe	city)	
<u>io</u>	endin ath. or: Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		rear)	Injury	М		es 2□No					
Š	or Att fter de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At hom <i>(Specify)</i>	ne, farm, s	treet, factory,	office		28f. Location City or To	(Street and Number or Rural Route Number, Town, State)			
	pltal ours a leral L		29a, Certifier 1 Certifying Ph	ysician: To the best of	my know	ledge des	ath occurred at	t the time	date and place	and due to the	2.0000000	a) and manner a	atatad	
	To the Hospital or Attending Physician: white 24 hours after death. To the Funeral Director: After this certification to the funeral director, to ompletely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director, the funeral director director director, the funeral director	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner	examinatio	on and/or i	investigation, i	in my opi	nion, death occu	rred at the time	e, date ar	nd place, and du	e to the cause(s)	
29b. Signature and title of certifier 29c. Licen									number		29d. Da	ate signed (Mon		
					V			CC	233	71	F	EB9,	2009.	
			30. Name and address of person who	completed cause of dea	ath (Item 2	23a) (Type	e, Print)		when	100	11	N 11	~ 1	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Şignatu	ire,	12 L	ue	JULIET (	avely	M	h 21;	200	
	Registr	-	FFR 1 8 2009	32. Registrar	1. 12	park				-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OZ **Physician** /Medical 4c. County of Deat 4b. City/Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 M 2 F 96 Yrs 217-14-8511 Director 6, 1912 Delaware Mar. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director MD Caroline Federalsburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Greenridge Road United States 21632 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sunshie Laundry (Grad.) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Hearn Iva Boyce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5258 Preston Road, Federalsburg, MD 21632 Ervan A. Lloyd/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cemetery 02/08/09 4 Donation 5 Dother (Specify) Federalsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** AvD/Medical Due to (or as a consequence of): **Examiner** athrosclorotic Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine for use as the burial-transiand Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician 9 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal dea
4 □ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy Month Day Year 5 Other (specify) detached ☐ Yes 2 ☐No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 ☐Unknowr Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate 1□ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. ပ 2 ER/Outpatient 3□ DOA 1 Inpatient 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005325

Registrar
DHMH 17 Rev 1/2001

State

Are Preston MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

136 Lednum

32. Registrar's Signature

Butter

Melinda Bu

FEB 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 18 per birth cert. G891 5/18/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mister 927 PM William laude February 5 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Frederick Calvert Hospital "alvert Memorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 16. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Months 1 XM 2 □ F 1919 217-16-7832 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Calvert 10c. City, Town or Location
Broomes Island 10d, Inside City Limits 10a State MARYLAND show r than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 8510 Church Road 20615 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 42 - 46ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5th Hygiene. College (1-4or 5+) seafood waterman 18. Mother's Name (First, Middle, Maiden Surname)

Patty-Smith Fannie Thomas 17. Father's Name (First, Middle, Last)
George E, Mister Be Ith and Mental 27 is marked o traumatic eve 19a. Informant's Name/Relationship (Type. Print)
Ida V. Mister- wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 34 Broomes Island MD 20615 and 2 Feb 7 12009 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Funeral Home Alexandria Virginia permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral HomePA 21. Signature of Funeral Service Licenses DY 4405 Broomes Is. Rd. Port RepublicMDS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 'erebellar **Physician** Acute /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2X No autopsy this certificate 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 6,2009 067594

Registrar DHMH 17 Rev 1/2001

State

Garkes

Road

Prince Frederick,

MO

20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18 2009

100

Hospital

32. Registrar's Signature

Chery Hepp, MI 31. Date filed (Month, Day, Year)

Hepp, MD

DIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 9, 2009 8:20 A Christine Troup McAdams /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 11525 Dellwyn Drive Hagerstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 212-24-3559 May 9. Maryland Director 80 1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Director Washington Hagerstown the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 2 a or ms 23a 11525 Dellwyn Dr. 21740 U.S.A. Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Yes 2K No Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Underwriter Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Strite J. Earl Troup 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara K. Hoover/Daughter 10813 Wyncote Dr., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages Department of I Important: If it any injury or o 1 X Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 2/13/2009 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S.M. 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) omanth **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and as the buriat-tra Due to (or as a consequence of) P.O. Box 68760. attending physician death certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached the 9□Unknown 9 ☐ Unknowf ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 1□ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire P 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: Injury (Month, Day Year) 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

30. Name and address of p

31. Date filed (Month. Day.

Year)

EB17

2009

DHMH 17 Rev 1/2001

Barke

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Betty Jean Miller 9:10 A M February 7, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NMS Health Care Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2**X** F 222-26-2492 66 **Director** Sept. 19,1942 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mertal Hygiene. Important: If tier 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Director PAFranklin Waynesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Wayne Ave. 17268 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: 3 ☐ Widowed 4 🖾 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Kerr Claire Newhouse 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Wayne Ave. Waynesboro, Pennsylvania 17268 Wanda Fuller (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State February Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 10, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO 14 14 MUIS 12525 Bradbury Ave. Smithsburg, MD 21783 Pert 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Rancer Small Cela /Medical Due to (or as a consequence of): **Examiner** Hypertans, on Sequentially list conditions es a consecuence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Year 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 ☐ № Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 MURSHED 21740 FARID MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEG 1

DHMH 17 Rev 1/2001

Registrar

		1 - State Registrar  1. Decedent's Name (First, Middle, La	st)		Cei	rtificate	OI D	eatn ———		ite of Dear	eg. No.	Vaca	3. Time of Death
Physic /Med		Patricia M.	Nob1e						IVI	onth	201	00	1440 1
Exam		4a. Facility Name (If not institution, given FRINSHIA REGION)	4b. City, Town, or Location of Death					4c. County of Death  Wicom ICO					
Funera	1	5. Social Security Number 6. 8	Sex 7. Ag	e (In yrs. last b		If Under 1		f Under 24 Hr Hours Mir	s. 8. Da	te of Birth			lace (State or Foreig
Directo	r	215381757 Usual Residence of Decedent	□M 2 <b>X</b> F	67	Yrs.	monaro a	,			/18/1		Mary	
land low		10a. State 10b. County		10c. City, Tov	vn or Lo	cation						1	0d. Inside City Limit
Many a-fsh	ctor	MD Somer	set	Pri	nces	s Anne							1 □Yes 2 N
ith the	Dire	10e. Street and Number		1		10f. Zip Co				1	0g. Citizen of	What Coun	try?
s 23a	eral	27840 Oriole Ro		F :: 11.0	140.1		1853				US		
filed within 72 hours after death with the Maryland Hygiene. Hygiene.  ther then "natural" or items 23a or 28a-f show ent, the Medical Evantinar mast ke notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐					anic Origin? ( Mexican, Pue	rto Rican,	etc.)		ce - Americ ck, White, e	
durs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	•	1	I∐Yes 2	(No	Specify:			Speci		ite
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within ene.	ld mc	Elementary/Secondary (0-12)	College (1-4or 5	5+)		OO NOT use r					O II-		
filed with Hygiene other ther ent, tre	Be Co	17. Father's Name (First, Middle, Last	none		HO	memake		B. Mother's Na	ame (First	, Middle, I	Own Ho Maiden Surna		
should be a marked o umatic eve	To B	Robert McCracken						Helen	Layfi	ie1d			
2 short and hard list ma		19a. Informant's Name/Relationship	Type. Print)	19	b. Mailin	g Address (S	treet and	d Number or F	Rural Rout	e Numbei	; City or Towr	, State, Zip	Code)
T and Health Health em 27 ther tr		Charles R. Noble	/husband					load, P					
Pages 1 nent of 1: int: If Ite		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □	Removal from State			sition (Name on natory or othe		7 0 /0	Date		20c. Location	•	'
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural" or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinating at Inciting Incitation Inciting Inciting Inciting Inciting Inciting Inciting Incitation Incit		4 Donation 5 Dother (Special 21. Signature of Funer Service Lice		St. Ar			-	a1 2/0		)9	Prince	ss Anı	ae, MD
Per Per Per Per Per Per Per Per Per Per	1	Man LOVINI	1 X h	100205				of Facility ral Ho		) i	A	M	D 210E2
	1	28a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	100295 the death. Do	not ente	er the mode of	omer of dying,	such as cardia	e., I ac or respi	ratory arr	ess An est,	ne, M	D 21853 Approximate Interval Between
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/Medical		resulting in death)	Due to (or as	a consequence	of):						<u> </u>		0 /
Examiner		Sequentially list conditions,	b. ACU	TE t	ER	NOTI	17	75					2 hours
uted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	PE 0	a consequence	01):	7 <	TIC	MAIT		OL	GAL		12 hour
be executed sician end burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):	- U - U	210	MOID		Chi	011		0.000
rificate be executed g physician end as the burial-transit	Aedical	•	d STE	RCOR	AL	UL	- Ct	ER				O	24 hours
		IF FEMALE:						•					
Physician: The law requires that the death cer this certificate has been signed by the ettendin ral director, page 2 should be detached for use	Physician/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal deat		Ectopic preg						ate of delive	ry Day Year
t the de by the c	ysic	1 □ Yes 2 🛣 No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 L	Other (speci	fy)						au, rou
that the		Part II. Other significant conditions	ontributing to death b	ut not resulting	in the un	derlying caus	e given i	in Part I.	23	Be. Did tob	acco use con	tribute to th	e cause of death?
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nysician: Thans certificate	Be (	25. Was case referred to medical examiner?	Hannitalı					6. Place of De	ath (Ched	k only one	e)		
Physic rathis or rail dire	2:	1 Yes 2 No	Hospital: 1 🗷 Inpatie	ent 2 ER/O	utpatien Time of			4 Nursing	_				)
<b>.</b> 50 0 0 0	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Injury	M 200.	Injury at Work? 1 □ Yes	ı s 2∐No	280. De	escribe no	w injury occur	rea	
Atten r deal ector: by the	ifica	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At home, f	arm, stre				28f. Lo	cation (St	reet and Num	ber or Rural	Route Number,
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysician: To the best niner: On the basis o and manner sta	f examination a	je, death nd/or inv	occurred at t restigation, in	the time, my opin	, date and place ion, death occ	ce, and du curred at ti	e to the cane time, da	ause(s) and mate and place,	anner as st and due to	ated. the cause(s)
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The same		1/6	A		D	1	04	1567	7		1/0	29/0	9
1,3		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, F	Print)	011	70.	<	- A1	1100	210-	/
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State of Maryland / Department of Health and Mental Hygiene 2009

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Thomas Osvatics  Physician
Dhysisia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

215-66-8021 1XM 2 F 46 Yrs. Months Days Hours Min. 08/03/1962 Foreign Country) Alaska  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits			I- For State Registrar		ate or ivial yland		cate of		rental Hy		g. No. 20	09 01	+8
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1   132   18   18   18   18   18   18   18   1	<u> </u>		10a. State	10b. County	- GI-		n or Locatio	on		·			_
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Secondary   Seco	nust be not		11. Marital Status		12. Was Deceder	?		Decedent of Hispania		ecify Yes or No-	14. Race - Ame	erican Indian, Blac	ck,
Scar W. Osvatics    Many R. Trueblood	"natural", c	a -	15. Decedent's E	ducation (Spec	orced If Yes, Give Year or Dates: ify only highest grade co	mpleted) 16a	. Decedent	's Usual Occupation (	Give kind of w				
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20. Method of Disposition   State   Committee   Comm	rked	e R				11	9b. <b>Ma</b> iling	Address (Street and				ite, Zip Code)	
A Dynation of Other Speciety   Larketitoria Country   Dynamics   Country   Dynamics	f Health an If item 27 i		20a. Method of Dis	position		20b. Place	of Disposi	ion (Name of cemeter					
23a Part   Enter the disease, or form(cation) that caused the death. Do not else the member of dying, such as cardiacor respiratory arest shock, or hear failure. List only one cause on exhaline.    23a Part   Enter the disease, or form(cation) that caused the death. Do not else the member of dying, such as cardiacor respiratory arest shock, or hear failure. List only one cause on exhaline.    23a Part   Enter the disease, or form(cation) that caused the death. Do not else the member of dispiration of the cause of death.	6) = 1 (		4 Donation 5	Other Spe	ecify:		nont M	Mem. Gards	02/0	06/2009 eall Fun	Davidson eral Home	ville, M	D_
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29c. License number 29d. Date signed (Month, Day, Year)  O.C.M.E.  February 3, 2009  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	al director, 1	0 26	examiner? 1 <b>✓</b> 'Yes	2 No	1 Impat			3 DOA Othe	4 Nursing	Home 5 F		er: Scene	
29c. License number 29d. Date signed (Month, Day, Year)  O.C.M.E.  February 3, 2009  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	death.		1 Natural	5 Pendi	ng igation Fd 2/3	/09 Fo	d 2:1	5 am 1 Yes	2 X No	unk			
29c. License number 29d. Date signed (Month, Day, Year)  O.C.M.E.  February 3, 2009  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	4 hours afte funeral Dir sky filled in		4 Homicide 29a. Certifier	deterr	mined (Specify)	residen	ce			or Town, Sta Bowie M	ate)13218 Ov	alstone	Ln
O.C.M.E. February 3, 2009  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To the F complete	Wedica	one) 2 🗸	Medical Exam	niner:On the basis of exa	amination and/or		on, in my opinion, dea	th occurred at		nd place, and due to	the cause(s)	_
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			aften	Beass	e (M)	donth (harring)							
			Melissa Bra	ssell, MD	Assistant Medica	l Examiner	111 Pe		more, MD 2	21201			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10:05 PM Poling 15 Marilyn McGinn 2009 Januar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1□ M 2XF 68 Director 143-30-3867 July 17, 1940 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 Saddle Ridge Lane 20850 <u>United States</u> Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Interior Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental H f Item 27 is marked otl r other traumatic ever McGinn Patrick Alice Erickson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a t: If Item 27 is / or other trat 507 Saddle Ridge Lane; Rockville, MD 20850 Donald Poling / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 1/29/2009 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the diseas shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kulmonary mmediat /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed? Yes 2 No 1 ☐ Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 Natural ours after death.

neral Director: A
filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0051791 January 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tamara L. Kile, D.O., 9901 Medical Center Drive, Rockville, MD 20850 Tamara L. Kile, D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 30 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of M	aryland / De	epartmen Certificat	t of H e of L	ealth a Death	and M		jien <b>e</b> (	009	04827		
Physic	cian	1. Decedent's Name (First, Middle, Las							2. Date of Dear Month	Day	Year	3. Time of Death		
/Med	lical	Lester Hamilton  4a. Facility Name (If not institution, give			4h City	Town or	Location of	of Death	<u> </u>	25 4c. C/	2009 ounty of Death	3:00P M		
Exam	iner	Washington Adven				oma I		J. 200		10.00	ounty or Dough			
Funera		5. Social Security Number 6. S	9x 7. Aq	ge (In yrs. last birth	day) If Under		If Under Hours	24 Hrs. Min.	8. Date of Birth	Year)	9. Birth	place (State or Foreign		
Directo	r	3.7 20 0307	M 2□F	84 Yr	s.	Dayo	1.00.10		6/6/192	24	USAN	ĬĆ		
iand iand		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits		
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altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours alt pperment of Heelth and Mental Hygiene. portant: if item 27 is marked other than "natural; or yinjury or other treumatic event, tra Medical Examination.	Co	8th grade  17. Father's Name (First, Middle, Last)		Spe	cial Po	lice			First, Middle, I		Enforce	ment		
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_ > 00	5.7	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D			28c. Injury Work	4 🗆 NU		me 5 Reside			(y)		
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Division tal or Attending s after death. Illustrictor: Afte	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of Ir	njury - At home, fam etc. <i>(Specify)</i>	n, street, factor	y, office			28f. Location (SI City or Town	treet and f n, State)	Number or Run	al Route Number,		
Division of to the Hospital or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Circut only one)  1 Certifying Ph 2 Medical Exam	ysician: To the besininer: On the basis and manner s	of examination and	death occurred or investigation	at the tim	ne, date an	nd place, ath occurr	and due to the co	ause(s) ar ate and pl	nd manner as s ace, and due t	stated. the cause(s)		
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6		1 Pull	new	re me	/	DO	185	2	Ĵ	ANU	My 29	2009		
*		30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Print)	ن بحر	12el 1	Hug	Houlle	· M	1207	31		
Segis	tate	31. Date filed (Month, Day, Year)	09 37 Regist	trar's Signature	backer	-								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:40 p M Donald Edward Praisner January 30 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1⊠M 2□F 76 Director 218-30-4929 September 09,1932 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Exacting cust be netfind at 1 ☐ Yes 2 ☑ No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2620 Shanandale Drive 20904 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ⊠Yes 2 ☐ No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1953-1955 1 ☐Yes 2 ☒No Specify ≥ 3 ☑ Widowed 4 ☐ Divorced "natural" White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "r t traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 4 Analyst C.I.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Edward Praisner Gladys Viola Rhoades 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Item 27 other t 95-1065 Loea Street, Mililani, Hawaii 96789 Karen Cheek - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ± 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 02/04/2009 Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Myelin 1, Klober 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician 1 month disease or condition resulting in death) Adenocarcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗆 No 1 □Yes 1 ☐ Yes Prospital or Attending Physician: 24 hours after death. 2 Funeral Director: After this certifica etely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0061033 31,2009 10+1 MAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Thambi, M.D., 9707 Medical Center Drive, #300, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 03 Registrar

DHMH 17 Rev 1/2001

January

Donald Praisner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Sereta Tessler Pinkus 2009 6:25 A<sup>M</sup> a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death The Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Months Days Hours 1 □ M 2 T F 10/13/1909 NY 055-34-7119 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Rockville Montgomery 1X Yes 2 □ No 10f. Zip Code 20852 10g. Citizen of What Country? United States Street and Number 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Tessler Rachel Chasan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Pinkus - Son 1710 East West Highway Silver Spring MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/09 Sharon Gardens Valhalla, NY 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): MALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery as decedent pregnant 3 Ectopic pregnancy the past 12 months? Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 21 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Department or Important: If any Injury or once. = 5

**Physician** 

/Medical

**Examiner** 

10a, State

MD

**Funeral** 

Director

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Funeral

Completed by

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Baltimore, Maryland 21215-0036

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After th funeral in 24 hours after death.

In Funeral Director: A pletely filled in by the fu death.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

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3 Suicide

29a. Certifier

4 ☐ Homicide

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8b. Time of

R/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 18084 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 MONTROSE

State Registrar

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To the within 2

Medical Certifica

31. Date filed (Month, Day, Year)

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7	Physician /Medical Examiner
	Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "netural", or Iteme 23e or 28s-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		State Registrar				Ce	rtificate of	Death			Reg. No.				
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	D 21031 1/26/09														
		30. Name and address of person	who complet	ed cause of de	ath (Item 1	23a) /Tuco		1100			1 (	-010	1		_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2000 /Medical County of Death 4a. Facility Name (If not institution, give, street and number) 4b. City, Town, or Location of Death Ac. Examiner Ft. Washington

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, 9. Birthplace (State or Foreign last birthday) 5. Social Security Number **Funeral** 1 □ M 2 □ / -26 Greens boro NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☐ No Funeral Director 000 Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 218 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2121No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's-Name (First, Middle, Last) Be mi P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) hington, DC \_ 90633 DIMID 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Riverdale Feb. Z. 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4 Signature of Funeral Service Lice rations that caused the death. Do not enter the mode of dying, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final athero Sclerotic **Physician** MENOW disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending p IF FEMALE: 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death
9□Unknown 5 Other (specify) ☐Yes 2☐No Ö the 9 Unknown signed by t d be detach <u>a</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, by 1 Tyes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy The death? 1 ☐ Yes performed? After this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Yes 1 Inpatient 2 R/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 Tyes 2 🗆 No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a, Certifier Limiting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the

State

2

31. Date filed (Month, Day, Year

29b. Signature and title of certifie

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

0000 5569

29d. Date signed (Month, Day, Year)

+ WAShi

		Please	State of Maryla					_	•			
		For State Registrar	State of Maryla	_	rtificate of			g. No. 200	9 04832			
Physicia	an.	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Dav Yea	3. Time of Death			
/Medic	al		ARIS		T 41. 00. T.	-1	Jan	4c. County of Death				
Examin	er	4a. Facility Name (If not institution, give		Center	1	r Location of Dea	ıtn		NONE			
Funeral		Social Security Number 6. S	7. Age (In yi	rs. last birthday		If Under 24 Hr: Hours Min		Year) 9. B	irthplace (State or Foreign Country) NEW YORK			
Director		092-58-4583		19 Yrs.			MAY 28,	1959	NEW YORK			
tryland show	Ļ	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits			
the Ma 28a-f s	ecto	MARYLAND ANNE A  10e. Street and Number	ARUNDEL		ANNA 10f. Zip Code	POLIS	140	Og. Citizen of What (	1 ☐ Yes 2 No			
If it is in the Maryland filed within the Maryland Hygiene.  The than "natural", or items 23a or 28a-f show ant, it is instituted at it.	Funeral Director	1601 LOCKSLEY DRIV	<i>7</i> E			21401			STATES			
r deat	nner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)					
rs afte	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 <b>X</b> No If Yes, Give Year or Dates:	1 □Yes 2 <b>X</b> No	Specify:	Specify: W						
72 hou		15. Decedent's Edu (Specify only highest grad	6b. Kind of Business/Industry									
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filed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last)			VICE PRE	T	ame (First, Middle, N	GRAPHIC faiden Surname)	AKTS			
uld be Menta Irked Itlc ev	To B	THEODORE R. WOOLS	₹Y			RUTH	TALMADGE					
Viali 12 sho h and is ma rrauma	ľ	19a. Informant's Name/Relationship (7					Rural Route Number,					
tem 2		HAROLD DEAN PARIS  20a. Method of Disposition	20b	. Place of Disp	osition (Name of		DUNWOODY,	GEORGIA 20c. Location - City of				
Pages Tent of Int: If i		1 ☐ Burial 2 🗷 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State CF	IESAPEAI INTER	KE'° CREMAT	TON JAN	UARY 24, 2009 S	TEVENSVIL	LE, MARYLAND			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Healt		21. Signature of Funeral Service Licens	see	C	2. Name and Addre	AND FUNE	LLOWS HE		AND NEWNAM			
1 205 g g		23a. Part 1. Enter the disease, or comp		O/Z RO	DAD, ANNA	POLIS, M	IARYLAND 2	1401	Approximate			
Physician		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		iter the mode of dyr	ng, such as cardi	ac or respiratory arre	<b>15</b> 1,	interval Between Onset and Death			
/Medical		disease or condition resulting in death)	a. Cirrosis  Due to (or as a cons						Zyrars			
Examiner	_	Sequentially list conditions, if any, leading to immediate	b									
uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):								
te be executed /sician and e burial-transit		that initiated events resulting in death) Last	Due to (or as e cons	equence of):								
ificate be g physici is the bu	dical	•	d									
death certificate attending physical for use as the b	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred	gnancy				23d. Date of o	lalivon.			
death de atte	iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time of 9 ☐ Unknown		□ Ectopic pregn <i>a</i> nd □ Other <i>(specify)</i> _	су		Month	Day Year			
uires that the de signed by the side be detached for	Phys	9 ∐Unknown		reculting in the	undoskija - anuan -ii	and in Dark I	22a Did tob	anno una contributa	to the course of death?			
w requires the been signed should be d	d by	Part II. Other significant conditions co	nuibaling to dealir but not i	esulang in the t	indenying cause gr	ven in Fart i.	1 \( \text{Ye}	1/	to the cause of death?  Probably 4  Unknown			
aw req	Completed						24a. Was ar		autopsy findings available			
The late ha	Ju o						- autops perform 1 □ Yes 2	y prior t ned? death MNo 1 □ Yo	o completion of cause of es 2 □ No			
VILA Ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital: 🔾		l Out		eath (Check only one					
Phys Prthis eral dir	:To	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of Injury	28b. Time	all 3 LI DOA		Home 5 ☐ Reside		pecify)			
ath. r: Afte	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year,	) Injury	of 28c. Inju Wor M 1 [	rḱ? ]Yes 2. □No		w mjary occurred				
or Atterde fleetde lin by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (Sti City or To wn	reet and Number or , State)	Rural Route Number,			
spital cours a neral D		29a. Certifier 12 Certifying Phy	ysician: To the best of my k	knowledge, dea	th occurred at the t	ime, date and pla	ce, and due to the c	ause(s) and manner	as stated			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  To the Funneral Director: Atter this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the tental physicompletely filled in by the funeral director, page 2 should be detached for use as the tental physicompletely filled in by the funeral director.	Medical	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	ination and/or i	nvestigation, in my	opinion, death oc	curred at the time, da	ate and place, and d	ue to the cause(s)			
To the with To the come	Σ	29b. Signature and title of certifier			29c. Licens	4		9d. Dat <i>e</i> signed <i>(M</i> o				
		70	VM.D.	tom 20=1 /7:		2980	7	ANNARY	21,2009			
CALH		30. Name and address of person who comes and the second se	i M.S. 26	lem 23a) (Type L South	Greene	St. Bo	Itimore.	MD 212	10			
Sta		JENNIZ LAN  31. Date filed (Month, Day, Year)  JAN 262	32. Registrar's Sig	gnature	1							
Registr	ar	JAN 20 A	.000 senera	p. 7	parke							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** George W. Perdue 22 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mamico MEDICAL 5441364R TENINSUM Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Year) Days 69 220-34-9952 1939 MD Director June 7, Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shov 1 XYes 2 ☐ No Director Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA ar than "natural", or items 23a 9133 Seahawk Rd. 21811 Completed by Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Medie once. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Construction 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elissa Purnell Clinton J. Perdue ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9133 Seahawk Rd., Berlin, MD 21811 Betty Jo Perdue/wife 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 20a. Method of Disposition New Bethel United

Methodist Church Cem 01/29/2009 Berlin, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Reproval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature III neral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A-luevo 3chevot, can diovarallow Diserce **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed hed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) walle wannu 32014

State Registrar

mioupua Maliely 31. Date filed (Month, Day, Year) 32. Registrar's Signature AN 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wister St SOUR Salle hory

MB 21804

09-00681 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anitra Pirkle State of Maryland / Department of Health and Mental Hygiene item#9,2,2,2009 Certificate of Death 1- For State Reg. No Registrar Amended 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 22, 2009 2156 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Penninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State of Foreign **Funeral** Country) Hours Director M 21 Yrs Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 28a-f show items 23a or 28a-f shoust be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, tranmatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 10 Yes 2 No specify: imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. f Yes, Give Year Specify: Widowed 4 Divorced If item 27 is marked other than "natural", <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19b. Mailing Address Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date City or Town, State Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State 01 Other Specify: Donation 5 9 22. Name and Address of Facility 21. Signature of Function Betwice Upensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Sharp Force Injuries Immediate Cause (Final disease xaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 ✓ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O.

within 24 hours after death.

To the Funeral Director;

completely filled in by the fi

page certificate

this

After

filled in by

Be

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Certification:

**Medical** 

1

2

3

and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)

Hospital: 1 V Inpatient 2

28a. Date of Injury (Month, Day, Year) FOUND:

Jan 22, 2009

(Specify) Field

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Nursing Home 5

performed?

28d. Describe how injury occurred

or Town, State) Williams Mill Pond Rd, Delmar, MD

Residence 6

✓ Yes 2

Subject assaulted

29c. License numbe O.C.M.E

26.Place of Death (Check only one

Other<sub>4</sub>

Yes 2 V No

28c. Injury at Work?

DOA

29d. Date signed (Month, Day, Year) January 23, 2009

death?

Other:

1 1 Yes

28f. Location (Street and Number or Rural Route Number, City

No

Pending

Investigation

Could not be

determined

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registra

25. Was case referred to medical

examiner?

1 V Yes

27. Manner of Death

Natural

Accident

Suicide

4 V Homicide 29a. Certifier

ER/Outpatient 3

28b. Time of Injury

FOUND:

2027 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	of Maryland /	Department of H		ental Hygie	ne	01 025
	_		State Registrar		Certificate of L	Death		no. 2009	U4633
	/sicia		1. Decedent's Name (First, Middle, Last)	2100			2. Date of Death Month	Day Year 2009	3. Time of Death
*	ledic amin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or	Location of Death	ren o	4c. County of Death	1
				reet	Cristie	ld		Somers	
Fune Direc			5. Social Security Number 6. Sex	7. Age (In yrs. last b	Yrs. If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Coun	1.1.
D			Usual Residence of Decedent	Jacob Situ Ter	wn or Location		Jep1 17,		ylana
farylar f show	ed at	5	Maryland Somerset		Field			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
n the h	notif	Director	10e. Street and Number		10f. Zip Code	_	10g.	Citizen of What Coun	try?
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "inatural", or items 23a or 28a-f show	nst be	ra D	127 Maple Street	•		817	Ur	ited States	<u> </u>
ter de	пeгп	Funeral	1 Never Married 2 Married 1 7 Ye	ecedent Ever in U.S. Forces? es 2 No	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe In, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036 ours af ral"; or	Exam	þ	If Yes.	Give r Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify: Bla	ack
15-0 72 ה "natu	edica	letec	15. Decedent's Education (Specify only highest grade complete		a. Decedent's Usual Occupa (Give kind of work done of life, DO NOT use retired	furing most of worki	ng 16t	. Kind of Business/Ind	dustry
212 d within	the M	Completed	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	Labor	,	N	Cready	Hospital
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental hygiene. 7 Is marked other than "matural", or	event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Mail		
laryland 2 2 should be filed and Mental Hygis Is marked other	matic	၉ .	George Biver  19a. Informant's Name/Relationship (Type. Print)		9b. Mailing Address (Street a	and Number or Burs	ra Vaig		Code)
e, Ma 1 and 2 s Health ar em 27 Is	er trau		Mary Paige / Sist			ipeake	$\circ$	sfield MC	21817
MOFE, Pages 1 arent of He	or other		20a. Method of Disposition  1. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	comoi	of Disposition (Name of tery, crematory or other place	e) C	Date 200	Location - City or To	wn, State
Pa Pa	ulnux (	i	4 □ Donation 5 □ Other (Specify)	Usb	Dry Cemete		1,2009 C	ristield,	Maryland
Balt permit. Departr Imports	any l		21. Signature of Fineral Service Licensee	MANNE	314 Coule	St Coss	Ciely E	daryland	21817
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do	not enter the mode of dyin	g, such as cardiac c	or respiratory arrest,	1017 10110	Approximate Interval Between
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/Medi Exami			Due	to (or as a consequence	e of):				
	-	ner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	To (or as a consequence	ല ഗീ).				
recuter	-transi	Examiner	that initiated events	to (or as a consequence	e off:				
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and			d	10 (01 40 4 0011004001101	o <b>0.</b> 7,				
rtificate	as the	Physician/Medical	IE FEMALE:						
Box 68 leath certific	or use	ian/	in the past 12 months?	outcome pf pregnancy ve birth 2 ☐ Fetal dea				23d. Date of deliver	ery Day Year
P.O.	iched 1	ysic		egnant at time of death nknown	5 Other (specify)				
IS, P res that signed b	e e	by Pt	Part II. Other significant conditions contributing t	o death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
cord w require been sig	plnou	ted					1 ☐ Yes	2√2 No 3 Prob	ably 4 □Unknown
Rec ne law has b	CI I	Completed					24a. Was an autopsy performed	prior to cou	psy findings available npletion of cause of
Division or Vital Records, lor Attending Physician: The law requires t after cleath.  Director: After this certificate has been signe	tor, pa	Be Co	25. Was case referred to medical			26. Place of Death	1□ Yes 2√2	No 1 ☐ Yes	2 No
hysicl	l direc	To B			Outpatient 3 DOA Other	er: 4 Nursing Hor	,	e 6 □Other (Specif	v)
On C	funera		Natural 5 Pending (A	ate of Injury Nonth, Day Year)	i. Time of 28c. Injury Worl	yat <br Yes 2 □ No	28d. Describe how i	njury occurred	
ViSion Attender death ector:	by the	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of injury - At home,	farm, street, factory, office		28f. Location (Stree	t and Number or Rura	l Route Number,
Divital or rall Divita	led in	Cert		uilding, etc. (Specify)			City or Town, S		
Division (To the Hospital or Attending Within 24 hours after death.) To the Funeral Director: After	completely filled in	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To 2 Medical Examiner: On the angle of the second of the	the best of my knowled the basis of examination a manner stated.	ge, death occurred at the tir and/or investigation, in my o	ne, date and place, pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
To the vithin	сошы	Mec	29b. Signature and title of certifier		29c. Licenso			Date signed (Month,	Day, Year)
			> W (>w	MD	Do	15715	2	2.3.09	
5 63			30. Name and address of person who completed of WILLAM GILL 264	23 Augral	(Type, Print)				
	Sta		31. Date filed (Month, Day, Year) 3	2. Registrar's Signature	han N. I				
Re	gistr	ar	FEB 04 2009	anna p.	Marie				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 ()

1- State Amended item#18, WCHD, SLU, 2/2/2009 Certificate of Death

Reg. No. 04836 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Palmer 0118A M 2009 Jeorge /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HICOMICA 5941364144 PENINSULA REGIONAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 2 M 2 □ F 219-36-7254 65 Maryland Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, Ite Medical Examination must be notified at 1 Yes 2 □ No Salisbury Director Maryland & COMEC 10f. Zw Code 10e. Street and Number 10g. Citizen of What Country? Mohaw 21801 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) abover 18. Mother's Name (First, Middle, Malden Surname) Sarah Curtis 17. Father's Name (First, Middle, Last) Be ၉ almer George 19a. Informant's me/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Coe) 817 Mohu OCIO ward 20b. Place of Disposition (Name of cometery, crymatory of other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Washington 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur Funeral Service Licensee 2184 land 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 72 h **Physician** Hemorrha disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HTN Sequentially list conditions, if any, leading to immediate cause. Enter und riving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≽</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2. No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ei (corral) 100 87 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Items 23e, 24, 25, 26, and 27 G888 dk
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 7:00 A M Robert William Plummer Feb. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany 13712 Cardinal Street Cumberland If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months 1 X M 2 □ F 212-24-0950 17, 1928 Maryland 81 Director Jan. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10b. County t be notified at 1 ☐ Yes 2 XNo LaVale MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 U. S. A. 441 Georges Creek Blvd "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 数Yes 2 □ No If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 Widowed 4 Divorced White 1947 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Hygiene. Tire Manufacturer 12 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H 7 Is marked traumatic ev Helen (Lowery) Plummer Orville S. Plummer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Daughter 13712 Cardinal Street, Cumberland, MD 21502 Sharon Hardinger other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 12 09 Cumberland, MD Hillcrest Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licenses 21502 1302 National Hwy., Cumberland, MD 23a. Faut 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cor Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi and Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month jo Day Year in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached for P.0. 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy has rmeg? XXNo 1∐ Yes certificate ospital or Attending Physician: Thours after death.

Ineral Director: After this certificate of the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home XXResidence 6 Other (Specify) 1 Yes 2∑KNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Year Division (Month, Day Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined To the Hospital within 24 hours a To the Funeral I 1 Pertitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD

Registrar
DHMH 17 Rev 1/2001

DK

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State

Ave.

Suite 400.

600 Memorial

Cumberland, Mp 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18 2009 Registrar's Signature

Sprenkle,

31. Date filed (Month, Day Par)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		Certificate of Death						Reg. No. 2009 048				
	Dhusiai		1. Decedent's Name (First, Middi	le, Last)						2	. Date of Death	Day	Vear	3. Time of De	
	Physicia /Medic		Jose	ephine Amand	a Quade	2					Month Februa:	ry 1,	2009	5:01	Ам
	Examin		4a. Facility Name (If not institution	n, give street and number,	)		4b. City, Tow	wn, or Lo	ocation of	Death		4c. Cour	nty of Death		
ari ari		*	21500 Oakley 1	Road			Ave						t. Mar	y's	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last b		If Under 1 Y Months D		If Under 2	4 Hrs. 8 Min.	Date of Birth (Month, Day, arch 27,	Year)	9. Birthp	lace (State or F	oreign
	Director		218-34-5308	TEW 241	73	Yrs.				N	March 27,	1935	Mary Mary		
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, To	wn or Loc	cation						11	0d. Inside City I	limits
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	he N 28a-1	Director	Maryland St.  10e. Street and Number	Mary's	Ave	nue	106 77: 0:		-			0	(110 + 0		XV.
	a or	ä					10f. Zip Co				10	g. Citizen d	of What Cour	itry?	
	sath	era	21500 Oakley Ro	12. Was Decedent	Ever in II S	12 1/	Vas Decedent	2060		in 2 /Cassi	fu Van au Na	14.5	USA		
	ter d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Mar	Armed Forces?	)	15. 1	Yes, specify	Cuban,	Mexican,	Puerto Ri	can, etc.)	14. Race - American Indian, Black, White, etc.			
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5	2 hou	Completed	15. Deceder	nt's Education	16	a. Deced	lent's Usual O	ocupati	ion		1	6b. Kind of	Business/Inc		
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7	d with	Ю	Elementary/Secondary (0-12)	Conege (1-401)		ealt!	n Care	Pro	vide	r		Nursi	ing		
2	al Hy othe	Be (	17. Father's Name (First, Middle,	Last)				18	8. Mother	's Name (I	First, Middle, Ma	aiden Surn	ame)		
<u>0</u>	should be filed within 72 hours after death with the Maryland and Mertled bylytiene. and Mertled other than "natural", or items 23a or 28a-f show umatic event, I'm Medical Evan mer mater to medified a	To	George William	n Owens					Mary	Lill	ian Phi	11sbu	ıry		
<u>a</u>	2 sho		19a. Informant's Name/Relations	ship (Type. Print)	19	9b. Mailin	g Address (St	treet and	d Number	or Rural F	Route Number,	City or Tov	vn, State, Zip	Code)	
	교육단부		James Bernard Quad	e / Husband		21500	Oakley 1	Road,	, Aven	ue, Ma	ryland 20	0609			
ב כ	of Her		20a. Method of Disposition	2	20b. Place cemen	of Dispos tery, crem	sition (Name of natory or other	of r place)	Ţ	Dat Tebrua	9 2	Oc. Locatio	n - City or To	wn, State	
altillo	Pag ment ant: I ury o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		l		orial Gar		· · · *	, 2009		eonard	ltown. N	Maryland	
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<u> </u>	99 F # 9	2 14	I / uchael 7	Lardine	er)						ı, Marylaı				
			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cause	d the death. De	o not ente	er the mode of	f dying,	such as c	ardiac or r	espiratory arres	st,		Approximate Interval Between	en
5	Physician		Immediate Cause (Final disease or condition			100	Y FA	14	INE				1	Onset and Dea	ath
	/Medical		resulting in death)	Due to (or as	a consequence	e of):					fi				
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6	attendin for use a	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal dea at time of death		Ectopic pregi Other (specif						Date of delive Month	ery Day Yea	ar
į	the o	Physiciar	1 □ Yes 2 <b>☑</b> No 9 □ Unknown	9 ☐ Unknown			TOTHER (SPECIA	.97							
F .	that ned b		Part II. Other significant condition	ons contributing to death b	out not resulting	in the un	derlying caus	e given	in Part I.	- 1	23e. Did toba	cco use co	ontribute to th	e cause of deal	th?
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2	r Atte er de recto by th	III)	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   28e. Place of In	jury - At home, tc. (Specify)	farm, stre	et, factory, off	fice		281	Location (Stre	et and Nur	mber or Rura	l Route Number	r,
5	tal or rs aft al Dii	Certification:		building, e.	ic. (Opecity)						City or Town,	Siale)			
		edical	29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the best Examiner: On the basis	of my knowled	ge, death	occurred at the	the time,	, date and	place, an	d due to the car	use(s) and	manner as s	tated.	
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	100		14	<i>p</i> -				$\nu$	1609	6		メー	4-09		
	1		30. Name and address of person  A J& W	who completed cause of a	death (Item 23a		Print)	. 7	ncen	10-10	= 11	0 1 1 1 1	(Coxe)	MDZ	(700
	Stat		31. Date filed (Month, Day, Year)	20 Devices	nerio Cinnoturo			7 /	75,00	ing Lt	3 , 110	WIN	W 00 P	NUK	1051
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 10:40 at January Lilly P. Ramsey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Sandy Spring Brooke Grove Retirement Village If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 4/29/1912 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 1 M 2 STF Massachusetts Director 578-52-5823 96 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Columbia Md.Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21045 5647 Thelo Garth Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8yrs. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance of the second se Amelia Barkos Louis Pappas ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5647 Thelo Garth Columbia, Md. 21045 s 1 and 2 of Health item 27 i Katherine V. Reese/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2009 Hanover, Md. Ardent Crematory 22. Name and Address of Facility Harry H. Witzke's Family F. II. Inc. 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YLS• Immediate Cause (Final Coronary Artery Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by Congestive heart failure, Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen Dementia, Failure to thrive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. spital or Attend nours after death meral Director: , y filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) February 2, 2009 D0057630

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun

10301 Georgia Ave. suite 209 Silver Spring, Md. 20902

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30, 2009 January 6:20 A Ellen Rodine /Medical Mary 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 😾 F **Director** Feb. 14,1923 85 Towa 484-18-4878 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It woulded Exartment with the Intilliand at 1 ☐ Yes 2 🙀 No Director St. Mary's Mechanicsville <u>Maryland</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 26098 South Sandgates Road 20659 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 √Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify <u>م</u> Specify: White 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ John Tilton Margaret Harnev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26098 South Sandgates Rd., Mechanicsville, MD 20659 Sandra Krush/Daughter 20b. Płace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State 02/02/2009 Mechanicsville, MD Mt. Zion Methodist 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brimerield, M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** months arcon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Physician/Medical Examiner Due to (or as a consec or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 TNo 3 TProbably 4 5 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 **N**O 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural s after death.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in within 24 hours a 29a. Certifier 🖭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one)

Maryland 21215-0036

Saltimore,

Box 68760.

P.0.

Records,

Division of Vital

State Registrar 29b. Signature and title of certifier

P

James

31. Date filed (Mo

Jarboe, M.D Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Leonardtown, Maryland 20650

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 1, 2009 Physician 8:05 P M Dora N. Rucker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert County 3451 Allday Road Huntingtown 8. Date of Birth (Month, Day, Year) 1930 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛛 F Days Hours Yrs. Maryland 78 **Director** <u>218-26-8092</u> Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: friem \$23a or 28a-f show important: if item \$7 is marked other than "natural", or items \$23a or 28a-f show important: if item \$7 is marked other than "national Examiner must be notified at once. Director 1 ☐ Yes 2 X No Calvert County Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20639 3451 Allday Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? ☐Yes 2X No 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Education Elementary/Secondary (0-12) College (1-4or 5+) Special Ed. Teacher's Aid Baltimore Co. Bd. of 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dora Tacker Lionel Bonnette ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3451 Allday Road, Huntingtown, Maryland 20639 (Daughter) Judith Yox 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 7. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 2009 Lee Crematory 21. Signature of 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disea complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No veral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 033123 February 2, 2009

dRW

State Registrar

31. Date filed (Month, Day, Year)

10845 Town Center Blvd., Dunkirk, MD 20754 Jonathan D. Lowenthal, M.D. 32. Registrarie Signature

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

**Physicia** /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Modeal Examinat must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit

Division of Vital Records, P.O. Box 68760,

Stat Registrar

	1 - State Registrar			Cer	tificate of .	Death			Reg. N	o.Z U	109	U48	46		
	1. Decedent's Name (First, Midd	fle, Last)						2. Date of Dea				3. Time of De	eath		
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al	4a. Facility Name (If not institution	an give street and a	(mhor)		4b. City, Town, o	r Location	of Death	Januar	-		of Death	3.30			
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					If Under 1 Year	SBURY If Under		Dona of Bird	45				E/		
	5. Social Security Number	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. 54	Yrs.	Months Days			8. Date of Birl (Month, Da	Day, Year)		9. Birting	place (State or F ntry)	-oreign		
	212-56-2269	1020	54	115.				04/29/	195	4	Del	aware			
	Usual Residence of Decedent		10- 6	y, Town or Loc	antina .						- 4	04 1-44-04	1 familia		
_	10a. State 10b. County										1	0d. Inside City			
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ie	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?						
=	7847 Esham R	≀oad			21849	1			USA						
ē	11. Marital Status	12. Was Dec	edent Ever in U.	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)								an Indian,			
'n.	1 ☐ Never Married 2 🔀 Ma	Armed F	orces? 2   No	0											
5	3 ☐ Widowed 4 ☐ Divorce	If Yes, G	ive	1 ☐ Yes 2 No Specify: Specify								nite			
Be Completed by Funeral Director				160 Doord	lant'a Hayal Occur	otion			105	Vind of D	vois one/le	ductor			
et	(Specify only high	nt's Education e <i>st grade</i> co <i>mpleted)</i>	)	(Give i	lent's Usual Occup kind of work done DO NOT use retire	during mos	st of work	ing	100.	KIII OI D	usiness/Ind	Justry			
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Be	17. Father's Name (First, Middle, Last)  Carroll Giordano  18. Mother's Name (First, Middle, Maiden Surname)  Margaret Rice										ne)				
ဂ															
	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi											Code)			
Dorrene Rice/wife 7847 Esham Rd., Parsonsburg, MD 21849  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State															
												wn, State			
	1 🗷 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hebron Cemetery 1/27/09 Hebron,														
	3. Signature of Funeral Service Licensee #Office and Address Funeral Home Professional 501 Snow Hill Rd., Salisbury, MD 2												.on		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,														
	23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the deat	h. Do not ente	er the mode of dyi	ng, such a	s cardiac	or respiratory a	rrest,			Approximate Interval Betwe	an .		
	Immediate Cause (Final				1	1	10-	- 0				Onset and De	ath		
	disease or condition resulting in death)	a. <u>CD</u>	www	9 1	NERY	1/	136	736				A FAS	- }		
	Due to (or as a consequence of):														
<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury														
in	cause. Enter Underlying	Z Due to	(or as e conseq	uence or):											
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ω	resulting in death) Last	Due to	(or as a conseq	uence of):											
//Medical Examiner		d													
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	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	tcome of pregna	ancy					23d. Date of deli			ery			
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ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 □ Unk													
문	Part II. Other significant condit	tions contributing to	death but not res	ulting in the ur	nderlying cause giv	en in Part	I.	23e, Did t	obacco	use con	tribute to the	ne cause of dea	ath?		
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C	25. Was case referred to medic							1 ☐ Yes th (Check only o	2 4	40	1 ☐ Yes	2 LI NO			
Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	11	10/0ut-ation	Oth	or.									
Ë	27. Manner of Death		Inpatient 2 🗷 e of Injury	28b. Time of				ome 5 Resi				y)			
<u>.</u>	1.☑Natural 5 ☐ Pendi	ing (Mo.	nth, Day, Year)	Injury	Wor	k? lYes 2□		Zod. Describe	now m	ury occur	rea				
cat	2 Accident Invest	tigation		<u> </u>		1165 2	1140								
Ħ		mined 286. Plac	e of injury - At n ding, etc. <i>(Sp</i> eci	ome, tarm, str <i>fy)</i>	eet, factory, office			City or To	street a wn, Sta	a <i>nd Num</i> i <i>te)</i>	ber or Hura	al Route Numbe	9 <i>r</i> ,		
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Ca	29a. Certifier 1 ☐ Certify (Check only 2 ☐ Medica	ring Physician: To that Examiner: On the	ne best of my kno	owledge, death	h occurred at the t	ime, date a	and place	, and due to the	cause	(s) and m	nanner as s	stated.			
Medical Certification: To	one)		nner stated.			_poii, de			- Gato 6	piace,	, and due li	2 410 Vau 30(3)			
Σ	29b. Signature and title of certifi	ier			29c. License number 29d. Date signe						ed (Month,	Day, Year)			
			MO		170	006:	2916	:	JA	NAA	NHAPY 26, 2009				
	30. Name and address of perso	n who completed as:	ise of death /Ita-	n 23a\ /Time											
		n who completed cal	S /4	/( Co.	Print) UTTH DIO	1150	al	SUITE	3 S	2,0	SURY	mozi	804		
	31. Date filed (Month, Day, Year		Registrar's Signa				-				- 17				
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1501M Robertson, Jr. Januar 2009 Raymond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TENINSULA SAC/SALIKY Viconic REGIONAL MESICAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 X M 2 □ F Hours 215-26-3939 Director 6-11-1929 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner number notified at **Funeral Director** 1X Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 West College Avenue 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 21 No Specify. Be Completed by If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Wicomico County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Raymond T. Robertson, Sr. Elsie Bozman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Debbie Hughes - Daughter 26334 Quantico Creek Road, Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-4-2009 Springhill Memory Gds: Hebron, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive cert disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Covoncy Arlera
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Atria attending physician and burlal-tran Due to (or as a consequence of) Box 68760. Re the IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 C Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 **N**O 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral D Medical 29a. Certifier 1 🖟 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISTO an 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** OMERO KOBERT FEBRUARY 10:15PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND GROVE ADVENTIST HOSPITAL MONTGOMERY SHADY 8. Date of Birth
(Month, Day, Year)
0 2 - 07 - 2009 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□F NONE MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "naturai", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at SPRING, 1 XYes 2 □ No **Funeral Director** MONTGOMER MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20903 8618 USA IVENUE Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2□ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) h and Mental F Be Komero Marrogui MERCEDES CORTEZ LUCAS LI LIANA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11TH AVENUE, SILVER SPRING, MD 20903 CORTEZ/MOTHER Health a LILIANA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State STERI 0 03/09/2009 HALL RIVER, NC CYCLE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility 9901 MEDICAL CENTER DR, KOCKVIIIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BIRTH EXTREMELY LOW 18 HRG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of r burial-transi Division or Vital Records, P.O. Box 68760,後 Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt be ( Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform certificate or Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 NO 1 Umpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Registrar

State

31. Date filed (Month, Day, -Year)

DR. ASTHANA, PEDIATRIX MEDICAL GROUP, 9901 MEDICAL CONTER DRIVE, ROCKVILLE

32. Registrar's Signature

02 Ruth Leone Rephan 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 79 May 4, 218-24-1243 1929 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at Director MD Frostburg Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 263 E. Main Street 21532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: <u>۾</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Cliffton Houck Lula Elfreda (Barncord) Houck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 263 E. Main St., Frostburg, MD 21532 Becky Rephan Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frost Eckhart Cemetery Feb 5 09 Eckhart, MD 21. Signature of Funeral Service Licensee John J. Hafer Jr. 22. Name and Address of Facility Hafer Frost Mansion 59 Frost Avenue, Frostburg, MD 21532 DO not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ademocalcinoma **Physician** Metastatic /Medical Due to (or as a consequence of): Small bould Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending pł for use as tl IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an cate has t

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. Amend I tem 20b and 21 per FH 6888 2/1 / 00 copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

Certificate of Death

	24a. Was an autopsy performed?  1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
26. Place of Dea	h (Check only one)
Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)
Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
ice	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)

Month

Day

04845

3. Time of Death

1149

9. Birthplace (State or Foreign Country) West Virginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

Few weeks

Pew weel

Year

1X Yes 2 □ No

Reg. No.

Day

Year

09

U.S.A.

Black, White, etc.

White

2. Date of Death

Month

(Check only one) 29b. Signature and fitle of certifier

29a. Certifie

25. Was case referred to medical

5 Pending

investigation 6 ☐ Could not be

determined

ma

1 Yes ﴾ No

examiner?

27. Manner of beath

Natural Accident

3 Suicide

4 Homicide

1 - For State Registrar

**Physician** 

1. Decedent's Name (First, Middle, Last)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

29d. Date signed (Month, Day, Year)

28c. Injury at Work?

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

1025 Avenue Cumberland, MD 21502 Kent 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Barks

State Registrar

certificate

After this

within 24 hours a

Be

Certification: To

Medical

To the Hospital or Attending Physician:

09-00557 Violette D. Strachan

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

e of Maryland / Department of Health and Mental Hygiene		2000	04846
Certificate of Death	_	 2003	04040

		1- For State Registrar			Certific	ate of	Death			Reg. No.	200	7 0407
Physici ledical Exami	an/	1. Decedent's Name (First, Midd Violette Ell	en Str	achan						y 19, 2009		3. Time of Death 1826 hrs
		4a. Facility Name (if not institute 3850 Enfield Chase C		and number)		4t	. City, Town, or I Bowie	ocation of	Death	1	county of Death	
Funeral		5. Social Security Number	6. Sex	7. Age (I	n yrs. last bir	rthday)	If Under 1 Year	If Under:			Forei	rthplace (State or
Director		578-40-7755	1 M 2	ХF	81	Yrs.	Months Days	Hours	Min. 4/2	7/1927	Co	ountry) DC
any:		Usual Residence of Decedent  10a. State  10b. County		10	c. City, Towr	or Locatio	n					10d. Inside City Limits
faryland 28a-f show any at ouce.	٥		e Geor	ges	Bov							1 X Yes 2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygier Mental Hygier at 77 is market of ther than "natural", or items 23a or 28a-f sho mustic event, the Medical Examiner must be notified at oucc.	Director	10e. Street and Number 3850 Enfield	l Chase	Court	#314		10f. Zip Code 20716			_	n of What Cou	
ath with	Funeral	11. Marital Status  1 Never Married 2 N	larried Arr	as Decedent Evened Forces?					n? (Specify Yes of Puerto Rican, etc.		4. Race - Ame White, etc.	rican Indian, Black,
after de	by Fu	3 Widowed 4 X Di	vorced or Date	Yes 2 X	No	1	Yes 2 X No	specify:		S	pecify: Bla	ck
5-0036 led within 72 hours after tygiene. other than "natural".		15. Decedent's Education (Spe					s Usual Occupati st of working life.			16b. Kir	d of Business	/Industry
36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12)		lege (1-4 or 5+) <b>5+</b>		Геасh	er			NY	City P	ublic School
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ	17. Father's Name (First, Middle							Name (First, Mid			
2121 2121 Juldbe fi Mental marked ic event,	To Be	Nicholas Duc		nt )	19	9b. Mailing			Antoine			e. Zin Code)
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygier Important: Iften 27 is marked other injury or other traumatic event, the M.		Jacqueline 1							Long Bea		90806	
ore, es lanc of Heal friten		20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Rem	oval from State	crema	atory or other	, ,		Date			r Town, State
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other S			Linco		emorial		1/27/200		tland,	
Bal permi Depar Impo injur	1	21. Sign, ture of Funeral Service	Licensee	SSV								ice, Inc. DC 20012
Physician		23a. Part I. Enter the disease, o failure. List only one cause		that caused the	e death. Do r							Approximate Interval Between Onset and
/Medical xaminer	6 9	Immediate Cause (Final disease or condition resulting in death)	_	osclerotic Ca		ular Dise	ase					Death
		Sequentially list conditions,	b	or as a consequ	iciice oi <sub>j</sub> .							
	miner	if any, leading to immediate cause. Enter Underlying Cause		or as a consequ	ience of):							ja
B ed	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (	or as a consequ	ience of):							
760, cate be executed physician and he burial - transi		UNPENDED	a AMEN	IDED				-				
8760, tificate being physic as the bur	n/Medical	IF FEMALE: 23b. Was decedent pregnant in	ho —	If yes, outcome					pregnancy		Date of delive	
Box 687 e death certifice the attending ped for use as t	siciar	past 12 months?	4	Live birth Pregnant at tim		2 Feta	al death 3 er (Specify)	Ectopic	pregnancy	.   "	Month	Day Year
. Bo the deat y the at	Phys	1 Yes 2 ✔ No 9 Ur  Part II. Other significant cond	tions contrib	Unknown	ut not reculti	na in the ur	nderlying cause o	iven in Parl	23e	Did tobacco u	se contribute to	o the cause of death?
ords, P.O. By v requires that the d	by	rattii. Other significant cond	tions contro	uting to death b	ut not result	ng in the ui	idenying cause g	ivei ili Fan				obably 4 V Unknown
ords, w require us been si should b	Completed									Was an		autopsy findings available completion of cause of
Reco	ошо				<u>-</u>					performed? Yes 2 No	death?	
Vital Rec ysician: The l his certificate l director, page	Be C	25. Was case referred to medic examiner?	al Hospital:					O11	Check only one)			
1 of Vital Records, ing Physician: The law requir After this certificate has been s uneral director, page 2 should I	욘	1 Yes 2 No 27. Manner of Death		Inpatient     Date of Injury		Outpatient . Time of In		y at Work?	Nursing Home 28d. Desc	Residen	ce 6 🗸 Oth	er: Scene
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Function Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ertification:	3 Suicide 6 Cou	ild not be		y - At home,	farm, stree	t, factory, office b	uilding, etc.		ion (Street an wn, State)	d Number or F	Rural Route Number, City
D lospital t hours uneral tly filled	C	29a. Certifier		pecify)	nowlodgo d	oath oscur	ad at the time de	to and place	ce, and due to the	causo(s) and	mannor as str	ntod
To the Hos within 24 h To the Fur	Medical	(Check only one) 1 Certifying Pone) 2 Medical Ex	aminer:On the									
_ /	Me	29b. Signature and title of certif		-//		)	29c. Licens				- '	fonth, Day, Year)
15		cauns	1		(		O.C.I	VI.E.		Janu	ary 20, 200	J <del>9</del>
		<ol> <li>Name and address of person Zabiullah Ali, M.D.</li> </ol>		ed cause of dea Medical Exa			Street, Balt	more, M	ID 21201			
	tate	31. Date filed (Month, Day Year	onno	62. Registrar's	Signature	har	7					
Regis	trar	JAN 3U 4	TOUS \	ensur	p. 19	parks	-		_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Fitter Registra WFNC#20bperFH2/2/09, FMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Harry Smolonsky 28, 2009 2:55 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 09/12/1917 Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 91 Pennsylvania Director 143-07-6286 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examinating uses to notified at 1⊠Yes 2 No Directo Prince Georges Maryland Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 Powder Mill Road #150 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel may Injury or other traumatic event, the Wedical Examinate and. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XXNo Specify: White Specify: ρ 3 Widowed 4 □ Divorced WWII Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Shoe Salesperson Wholesale Shoes 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hyman Smolonsky Golda Strovosky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc Smolonsky, son 608 McNeill Road, Silver Spring, MD 20b. Place of Disposition (Name of Garden control of Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date 0171728891 Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland Part En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 😷 Acute Renal Failure and -tra Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【X Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 ☐ Yes 2 🛛 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∏Yes 2 🛣 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D0064760 January 28, 2009 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mythily Vancha, 7300 VanDuesen Road, Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State JAN 30 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMFND#23a(b)perMD2-11-09,BMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month  $2^{\text{Day}}$ 200<sup>ear</sup> Evelyn Long Stalker January 10 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 07/21/1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 K F Months Min Days Hours 375-14-1009 89 Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 ll Brookes Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary/Treasurer Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Long Irena Haskin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Stalker - Son 11 Brookes Avenue Gaithersburg MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/01/2009 Kingsley, ME 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II 70 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Aspiration / Dysphagia Due to (or as a consequence of): Dementia Due to (or as a consequence of): 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

Director

Funeral

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Completed

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Maryland

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2 should be filed within 72 hours after and Mental Hygiene.

ō Department of Important: If it any Injury or o

Baltimore, Maryland 21215-0036

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and burial-trar

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

or Attending Physician; The law requires that the death certificate be executed attending physician for use as the buria signed by the a page 2 should certificate After this certification funeral director, p within 24 hours after death.

To the Funeral Director: A completely filled in by the form

Division of Vital Records, P.O. Box 68760,

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	Sequentially list conditions, if any, leading to immediate
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
	resulting in death) cast

	d
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death 9 ☐ Unknown
ort II. Other eignificant conditio	no contribution to doubt but not so sulli

					autopsy performed? 1 ☐ Yes 2 ▼ No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ Yo				
25. Was case referexaminer?	red to medical		26. Place of Death (Check only one)							
1 Yes 2	No	Hospital: 1 → Inpatient 2 □	ospital: 1 to Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	h 5 □ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,				
29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occur	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)				

						_
29b.	Signature	and	title	of	certifie	eı

29c. License number D68178

29d. Date signed (Month, Day, Year) January 27, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Santosh Rane MD 9901 Medical Center Drive Rockville MD 20853

State Registrar

10

31. Date filed (Month, Day, Year) FEB 03



To the Hospital

Physic /Medi Exami

Funeral Director

ſ	1 - State of N Registrar	laryland / Dep <i>Ce</i>	ertificate of l		Mental Hy	giene Reg. No. 20	09	04849			
ian	1. Decedent's Name (First, Middle, Last)  Carlos Edwin Stump		-		2. Date of De Month Februa	Day	Year 009	3. Time of Death 12:10 P M			
cal ner	4a. Facility Name (If not institution, give street and number	)	4b. City, Town, or	Location of Death			y of Death				
	Calvert Memorial Hospita		Prince F				Calver				
	579-64-3059 <sup>1⊠M 2□F</sup>	ge (In yrs. last birthday, 60 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Octobe	rth ay, Yea <i>r)</i> r 18,1948	9 Birthpla Count West	ace (State or Foreign ry) Virginia			
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10	d. Inside City Limits			
to	Maryland St. Mary's		Lec	nardtown	1	1 <b>X</b> ]Ye					
Direc	10e. Street and Number 41930 Nazareth Court	_	10f. Zip Code 206	50		10g. Citizen of What Country?					
nera	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S. 13.	. Was Decedent of H If Yes, specify Cuba		pecify Yes or No		ce - America				
Be Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates	] No	1 ☐ Yes 2 ☑ No	in, Mexican, Puerl Specify:	to Hican, etc.)		Black, White, etc.  Specify: White				
eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of wo	rking	16b. Kind of E	Business/Ind	ustry			
dmo	Elementary/Secondary (0-12) College (1-4or	·5+) I	DO NOT use retired lachine Me		J	Direct	Mail	Company			
S	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle	l e, Maiden Surna	me)				
To B	Charles Edward Stump			Mi1	dred Et	helyn Pa	arker				
	19a. Informant's Name/Relationship (Type. Print)		ing Address (Street								
	Chicchina Evelyn Stump / V	20b. Place of Disp	Nazareth	i	Date						
	1⊠ Burial 2 □ Cremation 3 □ Removal from State 4□ Donation 5 □ Other (Specify)    Cheltenham, Maryland Cemetery   Cheltenham, Maryland Cemetery   Cheltenham, Maryland Cemetery   Cheltenham, Maryland   Cheltenham, Cheltenham, Cheltenham, Cheltenham, Cheltenham, Cheltenham, Cheltenham, Cheltenham,										
	21. Signatore of Funeral Service Licensee  Muchael Hardy	ner) "	22. Name and Addres Mattingley P.O. Box 2	ss of Facility -Gardiner 70 Leonar	Funeral H	ome, P.A. 20650					
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximat Interval Bet Onset and I										
	Immediate Cause (Final disease or condition resulting in death)		hrs								
	Due to (or as a consequence of):  Aute Reval Failure.							days			
nine	Due to (or as a consequence of):  Due to (or as a consequence of):  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
edical Examiner	that initiated events resulting in death) Last  Due to (or as a consequence of):										
dica	d.										
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of deli										
hysicia	in the past 12 points?  1  Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown										
Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably Vinknow										
mplete					24a. Was		Were autop prior to con death?	psy findings available apletion of cause of			
	25. Was case referred to medical			26. Place of Dea	1□ Yes	2 No	1 ☐ Yes	2 No			
To Be	examiner?	tient 2 ER/Outpatie	ent 3 DOA Oth	er:		idence 6 □Ot	her (Specify	)			
ion:	27. Manner of Death  1 Natural 5 Pending (Month, Description)		Wor		28d. Describe	how injury occu	rred				
rtificat	2 Accident 3 Suicide 4 Homicide    Accident										
Medical Certification:	29a. Certifier (Check only 2 Medical Examiner: On the basis	of examination and/or i	ath occurred at the tir	me, date and place	e, and due to the urred at the time	e cause(s) and n	nanner as sta	ated. the cause(s)			
Med	one) and manner and manner and title of certifier	stated.	29c. Licens	e number		29d. Date sign	ed (Month, L	Day, Year)			
	> Faullen M	D	D6:	7647	-	2/	1/00	7			
	30. Name and address of person who completed cause of	death (Item 23a) (Type	Print) PRII	NCE	FRET	OFFIC	K,	MD			
ate rar	31. Date filed (Month: Bay, Year) 2009	strar's Signature	ad			- "					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 084 Kimberly Marie Stokes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINS YUA REGIONAL MENCAL NICOMICO SAUSBURY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min Months Days 1 □ M **25**F 222-58-5764 37 **Director** Oct.16,1971 Takoma Park, MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐Yes 2 PNo Director MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Caklee Drive 21826 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No δ Specify white Specify. 3 ☐ Widowed 4 ☐ Divorced "natural" Completed of Health and Mental Hygiene.
I Item 27 is marked other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 construction self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Kenlon Judy L. Elliott ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Elliott (mother) 320 Riblett Lane Wilmington, DE 19808 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Silverbrook Crematory Feb. 4,2009 Wilmington, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License MOO McCrery Funeral Homes, Inc. 3924 Concord Pike 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** luxel disease or condition resulting in death) xps s /Medical Due to (or as a consequence of): Examiner Pne to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate hes been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H61327 ss of person who completed cause of death (Item 23a) (Type, Print) St. Salisbury, MD 21801 Carroll

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

FEB 0 4 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien [ ] [ ] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0449 M Sharpless G-eraldine Mac 04 2009 03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deeth Examiner Memorial Itospital Oakland Garnett COI Garrett If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (Stete or Foreign Country) **Funeral** 1□M 20 F 82 213-24-6059 Director 08/01/1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Medical Exeminational to notified at 1 ☐ Yes 2 ☑ No Director Garrett Kitzmiller 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4984 Kitzmiller Road Be Completed by Funeral 21538 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 if Health and Mental Hygiene. College (1-4or 5+) Housekeeper Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alston Evans Alma\_ Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Sharpless, Husband 4984 Kitzmiller Road, Kitzmiller, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Zion Cemetery 2/6/2009 Mt. Zion, MD 22. Name and Address of Facility
Dayid A. Burdock Funeral Home,
710 Church St., Kitzmiller, MD 21. Signature of Funeral Service Licensee \* Katherine Sweiter 23a. Pert1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sersis weeks /Medical Due to (or as a consequence of): Cellulitis Examiner ection Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ⊡Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 64302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Dr. Daniel Buckingham, MD 255 North 4th St., Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB -5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 01, 2009 6:30PM Ellsworth Jerome Shockey /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Moran Manor Health Care Center Westernport Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F April 23, 1924 218-12-5488 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Des 2 No Directo Westernport Allegany Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21562 **USA** 25701 Shady Lane SW Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Airplane Q 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Shockey Clara Virginia Teasdale P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Bell - Sister 17104 Antique Road SW, Lonaconing, Maryland, 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date February 04 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland **Cumberland Crematory** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Srandi Lonaconing, MD 21539 8 East Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the Ó 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Sursing Home 5 Residence 6 Other (Specify) After this 27. Manner eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D21244 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Breadway Frustburg, Maryland H. TAW Je545 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Allliam sewel 8: UT AM 25 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince MI 5568 Frederick Charles tus hesville Date of Birth (Month, Day, Year) 3 / 3 1 / 1 9 5 1 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** Months Days 1**⅓**M 2□ F Hours Director 219-54-6890 57 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Widdel Examination and once. Yes 2 No Director Hughesville Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20637 USA <u>15568 Prince Frederick Rd</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Concrete Finisher Nazzrio Construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Sewell Monroe ဂ F. Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2063719a. Informant's Name/Relationship (Type. Print) <u>Thelma Sewell</u> / Mother 15568 Prince Frederick Rd, Hughesville MD 20c. Location - City or Town, State 20a. Method of Disposition Nation 2 ☐ Cremation 3 ☐ Removal from State 1/31/09 Bryantown, Maryland St.Marys Ch. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furleral Service Licenses 22. Name and Address of Facility 20608 Adams Funeral Home PA, Aquasco, Maryland 191 23a. Part 1. Enter the disease, or complications that caused the dunth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 24 hours after death.

Funeral Director: After the letely filled in by the funeral is 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertified 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The Poice 12070 Old Lie

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 30 2009

Shew B. Jan

12070 Old Line Center Ste 302 Waldorf Md. 2000-32. Régistrar's Signature, Lawer B. Lawer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 6:00 p 29, 2009 Sara Stein January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Montgomery 1121 University Blvd. West #1208 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Days 1 □ M 2 🛣 F 99 02/02/1909 Washington, DC 577-03-4323 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1⊠Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20902 1121 University Blvd West #1208 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2. XINo White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Rubin Herman Felter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3603 Gleneagles Drive lA, Silver Spring, MD 20906 William Stein, son 20b. Place of Disposition (Name of cemetery crematory or other place).
Ohev Sholom Talmud
Torah Cemetery 20c. Location - City or Town, State Date 20a Method of Disposition 1 → Burial 2 ☐ Cremation 3 Removal from State Washington, DC 02/01/2009 | 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 21. Signature a Fun and Barvice Licensee Danzansky-Goldberg Memorial
1170 Rockville Pike, Rockvil
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 Rockville Pike, Rockville, Maryland 20852 Immediate Cause (Final Acute Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): <u>Atherosclerosis</u> Sequentially list conditions, if any, busing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dite to (or as a ponswiguance of) Hypertension resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖾 No Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 【本No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ∐Yes 2X∑No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

Box 68760

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Examine attending physician and for use as the burial-transi Physician/Medical signed by the a Completed by cate has been si, page 2 should b certificate director, Be Certification: To this After thi funeral of s after death.

I Director: Afte in by the fur

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠ Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael M. Phillips, MD, FACP, PC, 2021 K Street, NW, Suite 412, Washington, 2006 31. Date filed (Month, Day, Year)

State Registrar

filled in

within 24 hor To the Fune completely fi

Medical

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 200 /Medical County of Death 4b. City, wn, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard Harmony Hall Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director DI December 04,1907 New York 579-03-3551 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturat", or items 23a or 28a-f show any Injury or other traumatic event, It we dical Examinat must be notified at 1 Tyes 2 No Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 6336 Cedar Lane, Apt. 131 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 kg No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify ò 3 X Widowed 4 ☐ Divorced Caucasian Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 5+ Personnel Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Adolph Singer ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10659 Green Mountain Circle, Columbia, Maryland 21044 Joan Singer Spicknall - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/30/2009 Adelphi, Maryland Mt. Lebanon Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. Mychin T. Wobect 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) Examiner Sagur ntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. É 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes No Be ( 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ Yo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

State Registrar

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31. Date filed (Month, Day, Year) 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier.

FEB

11055 Little Pataxon 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23 Ptili, 25 per me, 88 p. 03/06/09dip and Mental Hygiene trar Certificate of Death Reg. No. 1 - For A State Registrar N4856 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0940 Shelton Jerry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death : Examiner WICOMICO SAUSBURY Centu TENINSULA REGIONAL MEDICAL If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 10/27/1945 Birthplace (State or Foreign Country) **Funeral** Days Months 1**⊠**M 2□ F Hours 218-40-2758 Director 63 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director 28a-f Pittsville Maryland Wicomico death with the 10f. Zip Code 10g. Citizen of What Country? reet and Number ò USA 21850 items 23a 34966 Railroad Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

1s marked other than "natural", or iter 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 **X** No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🏲 No Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hatchery Manager Hudson Foods 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Keeney ပ Clifford Shelton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is 34966 Railroad Ave. Pittsville, MD 21850 Robin Shelton/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition injury or 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Salisbury Crematory 1/30/09 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd. Salisbury, Maryland 21804 21. Signature of Funeral Service Licenses Ē 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Premmer Conse Hardar disease or condition resulting in death) /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the for use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown corolac alopathe tran Completed director, page 2 should peen Renal Disease, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has autopsy Atherosclerotic Cardiovascular Disease certificate 1 □Yes 2 □ 25. Was case referred to medical examiner?

1 Yes 2 Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760 P.0. Records, Vital Division of Hospital or Attending

completely filled in by the within To the ٥ State Registrar

death.

hin 24 hours after deatl the Funeral Director:

the

29b. Signature and title on certifie

1 Natural

2 Accident

3 Suicide

29a, Certifier

Medical

4 Homicide

(Check only one)

5 ☐ Pending investigation

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. ζ, NIA 31. Date filed (Month, Day, Year) JAN30

32. Regi

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 □Yes 2 □ No

29d. Daje signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8 perFH, G888 2/26/09 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 Douglas W. Slaughter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner REGIONAL Wicanica FENINSULA. 51436414 MEDICAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 927 **Funeral** 1 M 2 □ F Months Hours 81 June 16,<del>200</del> Virginia 231-20-7887 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No in and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examinat must be notified. **Funeral Director** MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21801 USA 7469 Titleist Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Manufacturing 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther Slaughter Lillie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Heath ar Important: If item 27 is any injury or other trau 7469 Titleist Drive, Salisbury, MD 21801 Margaret Slaughter - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 2-2-2009 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 21. Signature of Funeral Service Licenses 22 Name and Address of Facility 705 E. Main Street, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final whomas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical signed by the attending I IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 □Yes 2 ☑ No After this certificate funeral director, pag 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death.

Funeral Director: After thi letely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide 29a. Certifier 📭 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the H
within 24
To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

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34.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N**2** 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 4:31 AM Stinefelt Wilma Februaru 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harbor Hospita Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216.68.3965 1 □ M 2 1 F Months Days Hours Director -27-Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10c. City. Town or Location 28a-f show event, the Medical Examiner must be notified at MO Funeral Director 1 ☐Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 23a or Pages 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes 2\_\_No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian. 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnote. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last Be ဂ 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY W. STINEFELT, HUSBAND 33021 PELEANS, MD. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Z-9-09 HANOVER, MD. 5 ☐ Other (Specify) 4 ☐ Donation Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Palmonary **Physician** Emboli /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death.

1 ☐ Yes 2 ☐ No autopsy this certificate 1 ☑Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 mpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A completely filled in by the f death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-00 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Baltimore

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Street

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31. Date filed (Month, Day, Year)

			For State	State of Marylan				ental Hy	giene		
			Registrar		Cer	tificate of	Death		Reg. No. 2	009	04859
	Physici	an	Decedent's Name (First, Middle, La ETHEL	stin Stin	71			2. Date of De Month	Day	Year	3. Time of Death
ر در چند	/Medic		4a. Facility Name (If not institution, given		177	4h City Town o	r Location of Death	FEBRUA		2009 unty of Death	11:05 A M
للد	Examin	EI	FOREST HILL HEALT		TION	FOREST				RFORD	
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	th		place (State or Foreign
	Director		186-01-5537	<sup>1□ M 2</sup> AF 92	Yrs.	Months Days	Hours Min.	Feb. 7	, 1917	7	WV
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					0d. Inside City Limits
	f sho	or	MD Harfo			l Air					1X Yes 2 No
	the N 28a-	Director	10e. Street and Number	Tu	ье	10f. Zip Code			10g. Citizer	of What Cour	ntry?
	3a or	iO le	555 S. Atwoo	d Road			014		-	S.A.	, .
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V		lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No	- 14.	Race - Americ	
٥	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dioal Examiner must be notifiled at		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:	nican, etc.)		Black, White,	etc.
2-003p	ural",	d by	3 AWidowed 4 ☐ Divorced							W	hite
7	n 72 "nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	Give	ent's Usual Occup kind of work done OO NOT use retired	ation during most of workir d)	ng	16b. Kind	of Business/In	dustry
7	l within jiene. r than " the Mec	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	1	teria W	•		Edu	ıcatio	n
9	be filed within 72 ho tal Hygiene. d other than "natu event, the Medicl	Be C	17. Father's Name (First, Middle, Las	t)	1		18. Mother's Name	(First, Middle,	Maiden Su	rname)	· · ·
/lan		To E	Ollie Sheets				Elizabe	eth Mi	ller		
<u>a</u>	2 sho and is ma		19a. Informant's Name/Relationship				and Number or Rura				
≥ (i)	s 1 and 2 should F Health and Mer tem 27 is marke other traumatic		Delores DeVoe/				Drive,		<u> </u>		
ב ב	9 0 <del>L</del> >		20a. Method of Disposition 1 H Burial 2 ☐ Cremation 3	${\tt I}$ Removal from State ${\tt Su}^c$	emetery over Squeha	sition (Name of natory or other place anna Garden	Feb.	12,		ion - City or To	own, State
baitimor	artmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Special Service Lice					09	_Yor	k, PA	
g D	permit. Pag Department Important: I any Injury o		James J.	Hartente	1	9 S. Mai	ss of Facility J. n St., St	J. Har ewarts	tenste town,	ein Moi Pa 17	rtuary, Inc 363
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death one cause on each line.	h. Do not ente	er the mode of dyir	ng, such as cardiac o	r respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lundia.	anez	7					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consequ	uence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Ď	an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
<b>68/60</b> ,	ificate be executed g physician and as the burial-transit	edical		<b>▲</b> d	-··· <u>-</u>						
	ertifica ing ph e as t	Med	IF FEMALE:								
o n	w requires that the death certific been signed by the attending E should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1☐Live birth 2☐Feta	Ideath 3□	Ectopic pregnancy	1		23d	. Date of delive Month	ery Day Year
	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of do 9□Unknown	eath 5∟	Other (specify) _					Day Tour
Ţ.	requires that the een signed by the		Part II. Other significant conditions	contributing to death but not resi	ulting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to the	ne cause of death?
cords,	quires n sign ald be	d by	dementa					101	Yes 2□1	lo 3 ☐ Prob	pably 4 Unknown
eco	law rec as beel 2 shou	Completed	COPD					24a. Was	an 2	4b. Were auto	psy findings available
ř	9 <u>2</u> 9	omp	CHT			<u> </u>			osy moed? 2 No	prior to con death?	mpletion of cause of
VIII K	ian; ertifica etor, p	Be C	25. Was case referred to medical examiner?				26. Place of Death			T LITES	21400
Ž	physician; Th this certificate al director, pag	10	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient		4 Nursing Hon	ne 5□Resid	dence 6	Other (Specif	y)
0 [	ding Physician; h. After this certific funeral director,	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	now injury o	ccurred	
VISION	ttend death stor:	icati	2 Accident investigation 3 Suicide 6 Could not be	De 200 Plans of injury. At he	una farm atra		Yes 2 No	205 1 //	24		
2	after a	Certification:	4 ☐ Homicide determined	building, etc. (Specify	y)	et, factory, office	4	City or Tou	vn, State)	umper or Hura	I Route Number,
	spita nours neral / filled	S =	29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge, death	occurred at the tir	me, date and place, a	and due to the	cause(s) an	d manner as s	tated.
	the Hospital or Attending Physician; the Anours after death. The Lathours after death the Enderal Director: After this certifical mpletely filled in by the funeral director,	edical	(Check only 2 ☐ Medical Exa one)	miner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my o	ppinion, death occurre	ed at the time,	date and pla	ace, and due to	the cause(s)
	To the le within 24	M	29b. Signature and title of certifier			29c. Licens	e number		29d. Date si	igned (Month,	Day, Year)
			Davel 55	·		03	2-277		F - 616	000 7	,2009
			30. Name and address of person who							,	,
			DR. DAVID DUNN — 31. Date filed (Month, Day, Year)	615 W. MACPHA		O - BEL A	IR, MD 21	014			
	Sta Registr		FEB 1 7 200		A DR	Hard)					
			1 1 2 - 200	- /	12						

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of I	•	Department of F Certificate of I				04860
		e	1. Decedent's Name (First, Middle, Last)		Certificate of I	Jealli	2. Date of Death	g. No. 2009	3. Time of Death
	Physicia	an	Helen Lewis Tebeleff				Month	28, 2009	6:00 p M
	/Medic		4a. Facility Name (If not institution, give street and number	ar)	4h City Town or	Location of Death	January	4c. County of Dea	
	Examin	er	Holy Cross Hospital	.,	Silver S			Montgomer	
	Funeral			Age (In yrs. last birt	thday) If Under 1 Year		8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		578-34-4683 1□ M 2K□ F	85	Yrs. Months Days	Hours Min.	05/04/1	923 Wasi	nington, DC
	pu ,		Usual Residence of Decedent	10- Oit T					10d. Inside City Limits
IK	arylau shov	<u>_</u>	10a. State 10b. County Maryland Montgomery	10c. City, Town	Spring				1X Yes 2 □ No
JA"	he Ma	Director		511,01	10f. Zip Code		10	g. Citizen of What Co	
	with t		10e. Street and Number 3200 North Leisure World	D1 #51				SA	ound y :
	eath	Funeral	11. Marital Status 12. Was Decede		13. Was Decedent of H	ispanic Origin? (Spe		14. Race - Ame	erican Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventine must be partified at once.	by	Armed Force  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  Armed Force  1 □ Yes 2 □  If Yes, Give Year or Date	s? █ No	If Yes, specify Cuba	an, Mexican, Puerto F Specify:	Ricán, etc.)	Black, Whit	e, etc. White
2-0	2 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done of		1	6b. Kind of Business	/Industry
21	thin 7	nple	Elementary/Secondary (0-12) College (1-40)	or 5+)	`life. DO NOT use retired	i)			
21	ed wi	ပ္ပ		Sec	retary	18. Mother's Name		US Govern	nent
and	3.2 should be filed within th and Mental Hygiene. 7 is marked other than "traumatic event, the Me	æ	17. Father's Name (First, Middle, Last)  Saul F. Lewis			Tillie Bl		aideil Surriame)	
ž	hould d Mei marke matic	은	19a, Informant's Name/Relationship (Type, Print)	196	. Mailing Address (Street			City or Town State	Zin Code)
	nd 2 s Ilth an 27 is u		Gilbert Tebeleff, husband		200 North Le				L.P 0000)
ē,	s 1 and 2 if Health item 27 i		20a. Method of Disposition	20b. Place of	f Disposition (Name of ry, crematory or other place	D. D.		0c. Location - City or	Town, State
m 0	Page:		1 Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te Judean	n Memorial G	dns 01/30,	/2009	Olney, Mai	cyland
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee	-	22. Name and Addre Danzansky- 1170 Rocky	ss of Facility Goldberg N	Memorial	Chapels,	Inc.
			23a. Part 1. Enter the disease, or complications that cau	sed the death. Do r					Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition Pancre	atic Canc	or				Onset and Death Years
	/Medical			as a consequence of age Renal					
	Examiner								Months
2	ed sit	Examiner	cause. Enter Underlying	as a consequence o	of):				
	xecut and al-tran	xan	resulting in death) Last  C. Pneumo  Due to (or	nla as a consequence o	of):				Weeks
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289	ificate g phy as the	edic	U						
.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		h 2  Fetal death it at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		23d. Date of de Month	livery Day Year
Э,	s that gned t		Part II. Other significant conditions contributing to deat	h but not resulting ir	n the underlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ğ	w require s been sig should b	edt					1 ☐ Ye	s 2 <b>M</b> No 3□ P	robably 4 🗆 Unknown
I Records,	The law re ate has be page 2 sho	Completed by					24a. Was an autopsy perform 1 □ Yes 2	prior to	utopsy findings available completion of cause of
Vital	ysician: The is certificate h	Be (	25. Was case referred to medical examiner?		¥ 1. 1257.	26. Place of Death	(Check only one	)	
of \	Physi this c		1 Yes 2 No Hospital: 1 King	·	utpatient 3 DOA Oth	4   Nursing Hor	**	nce 6 Other (Spe	ecify)
n C	ding Ph. h. After thi funeral	ion:	TE Hattial 5   1 ending		Time of 28c. Injur	ry at k?  Yes 2 □No	28d. Describe hov	w injury occurred	
isi	I or Attendi after death. Director: A	licat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of	Injury - At home, fa	rm, street, factory, office		28f. Location (Str	eet and Number or F	ural Route Number.
Division	al or A after Directly	Certification: To	4 Homicide determined building	etc. (Specify)	,,		City or Town,		
£	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Sertifying Physician: To the base and manne	is of examination an					
	To th withi To th	ž	29b. Signature and title of certifier		29c. Licens	se number	29	d. Date signed (Mon	•
	10		Barbara Suppried	1, R8M, L	Do Do	065485	-	01/28/	12009
			30. Name and address of person who completed cause Barbara Supanich, 1500 Fo			er Spring,	, Maryla	,	/
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 3 0 2009  Senter	istrar's Signature	partie				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04861 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 30 2009 O M 01 1:20 ELLEN RAE GOODMAN TUCKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY MATHUCION ANGENT MKUMA PARK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□ M 2\X Days Hours 226-28-5863 85 DEC. 19, 1923 VIRGINIA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Director BRENTWOOD MD. PRINCE GEORGES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3504 TAYLOR ST. 20722 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ KILLIS HENRY GOODMAN VIRGINIA GUILL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TUCKER/DAUGHTER LINDA Μ. TAYLOR ST., BRENTWOOD, MD. 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 2-5-2009 LYNCHBURG, VA. 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 21. Signature of Funeral Service Licensee M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a ATREDISCURDING CARDIOLATEULAR Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician/Medical

**Physician** /Medical **Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Evantmer must be notified at once.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and

P.O. Box 68760.

Division of Vital Records,

after death Director:

Sulling in death, East	d	:				
FEMALE: 8b. Was decedent pregnant in the past 12 montis? 1 □Yes 2 DNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of Month	delivery Day	Year
rt II. Other significant condition	s contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobacc	co use contribute		se of death?

ed pa		Tributing to death but not rest	uning in the underlying	cause given in Part i.	1   Yes 2   No 3   Probably 4   Onknown
Completed					24a. Was an autopsy autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?			26. Place of	Death (Check only one)
2	examiner? 1 Yes 2 No H	lospital: 1 ☐ Inpatient 2 🚍	ER/Outpatient 3 🗆	DOA Other: 4 I Nursir	ng Home 5 ☐ Residence 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specification)	ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurrention and/or investigati	ed at the time, date and p on, in my opinion, death o	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)
ž	29h Signature and title of certifier		2	29c. License number	29d Date signed (Month Day Year)

29c. License number

De MKOMA PARK MD

29d. Date signed (Month, Day, Year)

01-301-2009

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 Canoll

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 7:53 pM John Samuel Templin 2009 25 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice - Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☑ M 2 □ F Yrs. December 05,1919 89 Pennsylvania Director 168-14-6260 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Director Maryland Montgomery Brookeville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20833 U.S.A. 21300 Ridgecroft Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:1939**-1**960 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pilot USAF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental H 27 Is marked ot traumatic ever ဥ Jesse G. Templin Florence Sanner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any injury or other trau once. Helen Templin - Wife 21300 Ridgecroft Drive, Brookeville, Maryland 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/12/2009 Arlington National Cemetery Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 (QQ 23a. Part 1. Enter the disease, shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anly one cause on each line. Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) <u>Endsta e Renal Disease</u> /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Severe Right Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐Yes 2 ☒ No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ♦☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 🕮 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mu reneve D0064615 January 30, 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 03 Registrar

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2009 0486	-
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death	_
	Physic /Medi		Estelle G. Thomas January 30 2005 9:22 p	
and the same	Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	_
			Civista Medical Center ha Plata Charles	
8	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Forei Country) 9. Birthplace (State or Forei Country)	gn
2	Director		219-14-3090 12 08/ 24 Myyland	
:1	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	te
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0	filed within 72 hours after death with the Marylan Hygiene. Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Mydical Evry, fract rust be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Bane - American Indian	_
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27	filed v Hygid other i	ပ္သ	17. Father's Name (First, Middle, Last)  Processing Line Worker Seafond Industry  18. Mother's Name (First, Middle, Maiden Surname)	_
anc,	d be fantal	Be	Cannot E	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Mental Aumatic event, the Mental aumatic event, the Mental aumatic event and aumatic event aumatic	မ	Samuel E. Green Annie M. Gross  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	_
	ロサイヤ		EMME ++ Tolliver 5623 Gates St. Royal Oak, Maryland 2166	)
ē,	es 1 and 2 of Health of Item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of bate 26c. Location - City or Town, State	^
Ë	Fage nation		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Richards Mem. Park 2/7/09 Easton, MD.	
Baltimore,	permit. Fages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	
œ			Janelle Co Henry Henry Funeral Home, P.A. Jan MD. 2/6/3	
			23a. Parr f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition Onset and Death	
0	/Medical Examiner	l X	resulting in death)  Due to (or as a consequence of):	
	LAaiiiiiei	<u>.</u>	Sequentially list conditions, b. Cardio myopethy, renel failure and advanced	
	ted	jë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
	xecu and	Examiner	resulting in death) Last  c.   Due to (or as a consequence of):	_
68760,	icate be executed physician and s the burlal-transit	dical		
687			d.	
Вох	eath certific attending p for use as	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
	deat deatt	sicie	In the past 12 mg/fiths?  1	
P.0	w requires that the death certiis been signed by the attending should be detached for use a	Completed by Physician/Me	9 LJ Unknown	
s,	res th	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
0.0	requi	ted	Hypertension, pacemaker, CHF, prior MI, HLP 1 Ves 2 No 3 Probably 4 Unknown	1
Sec.	2 % B	nple	Recent admission for acute CHF exacer bation  24a. Was an autopsy prior to completion of cause of	Э
alF	Th ate		performed?/ death?   1 □ Yes 2 □ No	
Z.	Physician; r this certific ral director, I	Be	25. Was case referred to medical examiner?  1   Yes   2   Value   1   Ves   2   Value   1   Ves   2   Value   1   Ves   2   Value   1   Ves   2	_
of	Physer this eral di	Ę.	1 ☐ Inpatient 2 ☐ EH/Outpatient 3 ☐ DOA ☐ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
on	Attending It death. Sctor: After by the fune	ţi	27. Manufer of Death 28a. Date of Injury 28b. Time of 1 Natural 5 □ Pending (Month, Day, Year) 28b. Time of 1 Natural 5 □ Pending 1	
Division of Vital Records,	Atter r dea ector by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Burel Boute Number)	-
á	s afte	Certification: To	4 Homicide determined building, etc. (Specify)  building, etc. (Specify)  building, etc. (Specify)	
	lospit t hour unera		29a. Certifier (Check only appl) (Check only app	_
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical	and manner stated.	
	vit Cor	-	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
	1	-	Ctenn Burgs, MD. Emersency Physician D64924 January 30, 2009	_
	M		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CLENN BURNS M.D. 15900 COUNT DRIVE BURNSWILLE MD 20413	
	Sta	te	GLENN BURNS, M.D., 15900 COLWELL DRIVE, BRANDYWINE, MD 20613  31. Date filed (Month, Day, Year)  FEB 0 4 2009  32. Registrar's Signature  A. Aprille	_
	Registr	ar	TEBU 4 2009 Kenna B. Aparter	

DHMH 17 Rev 1/2001

			_ For	State of Marylan				Mental Hygi	ene		
			State Registrar		Cer	tificate of	Death	Re	g. No.?	19	01.864
	Physici	an	Decedent's Name (First, Middle, Las					Date of Deatl     Month	Day	Year	3. Time of Death
	/Medic			MAN	T				<del> </del>	009	1058 ™
)	Examin	er	4a. Facility Name (If not institution, give Shady Grove Ad		nital	Rockv.	r Location of Deatl	1	4c. County		PDV
	Funeral		5. Social Security Number 6. So			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
	Funeral Director			<b>X</b> M 2□F 75	Yrs.	Months Days	Hours Min.	Feb. 6	1933	Cour	ryland
	D		Usual Residence of Decedent	140-00							
	arylar show d at	_	10a. State 10b. County		y, Town or Lo						0d. Inside City Limits 1√2 Yes 2 □ No
	he Ma 18a-f	Director		omery	Roci	kville		1 1/	g. Citizen of V	What Cour	
	a or 2		10e. Street and Number	ll - Dood		208	F 0				uy:
	eath	Funeral	604 Great Fa	12. Was Decedent Ever in U	.S. 13. V	Was Decedent of H		pecify Yes or No-	14. Rac	A. e - Americ	
2	after o	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes ②☑ No If Yes, Give	1	f Yes, specify Cub 1 □ Yes 2 ½No		to Rican, etc.)		k, White,	
2	be filed within 72 hours after death with the Maryland Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	l by	3 ☐ Widowed 4 ☐ ₩ ivorced	Year or Dates:		TLI Tes ZLXINO	Specify:			Blac	
5	72 h "natu edical	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	nation during most of wo	rking	16b. Kind of Bu	isiness/Ind	dustry
7	within ene. than he Me	duo	Elementary/Secondary (0-12)	College (1-4or 5+)		rpenter	u)		Saah E	ימינוני	iture Co
V 5	filed Hygid Sther ent, th		17. Father's Name (First, Middle, Last)		Ca.	pencer	18. Mother's Nar	ne (First, Middle, M			cure co
0	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	UNK				Netti	e Twyma:	n		
<u>a</u>	should and Men s marke umatic	-	19a. Informant's Name/Relationship	Type. Print)	19b. Mailin	ng Address (Street	and Number or Ri	ural Route Number,	City or Town,	State, Zip	Code)
Ž	and 2 ealth a n 27 Is er trai		Joyce Fuller-H	arber			_				MD 20871
ט	Pages 1 and 2 should be filed within 72 hours after death with the Marylan rent of Heath and Mental Hygiene. Int: If teem 27 is marked other than "natural", or items 23a or 28a-f show int or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			sition (Name of matory or other pla			20c. Location -		
	. Рас tmen tant: tant:		4 ☐ Donation 5 ☐ Other (Specify	) Je	~ N			1/30/09			•
Da	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.		21. Signature by Funeral Service Licen	Rand							OME, P.A. MD 20850
ľ	۲		23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused the deat	h. o not ent	er the mode of dyi	ng, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
ş	Physician		Immediate Cause (Final disease or condition resulting in death)	a Enteroco		Sepsis					4 days
•	/Medical Examiner		Tooling in dod.ii)	Due to (or as a conseq							
Wb.	¥	er	Sequentially list conditions, if any, leading to immediate	b. Congestic	ve Hea	art Fai	lure De	compens	ation		1 days
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Pneumoni	a						
<u>,</u>	e exe ian ar ırial-tı		resulting in death) Last	Due to (or as a conseq	uence of):						
0000	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d							
ο Χ	sertific ding p	Me	IF FEMALE:	23c. If yes, outcome pf pregna	ancy				004 D-		
2	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 □Live birth 2 □ Feta 4 □ Pregnant at time of c	ıl death 3 □	Ectopic pregnanc Other (specify)	у			te of delive inth	Day Year
	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown							
Ĺ	s that ined b	by PI	Part II. Other significant conditions	ontributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use cont	ribute to th	ne cause of death?
cords,	en sig							1 □ Y∈	s 2 No	3 ☐ Prob	ably 4 ⊠Unknown
S S	law ri as be 2 sh	Completed						24a. Was ar autops	y	Were auto	psy findings available mpletion of cause of
	The ate h page	Som						perform	ned?	death? 1 □ Yes	2 □ No
ומ	clan: ertific	Be	25. Was case referred to medical examiner?	Hoopitals				ath (Check only one	9)		
5	Physi this c	၉	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 15 Inpatient 2 2	ER/Outpatien 28b. Time of	IL OLIDON		lome 5 ☐ Reside			y)
5	ding   h. After funer	ion	1 ■ Aatural 5 Pending	(Month, Day Year)	Injury	Wo	rk?  Yes 2∐No	280. Describe no	w injury occur	ieu	
2	r Atten er deat rector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		l ome, farm, str fy)	eet, factory, office		28f. Location (St. City or Town	reet and Numb	er or Rura	al Route Number,
בֿ	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	al Cer		ysician: To the best of my kno	owledge, death	h occurred at the ti		e, and due to the ca	ause(s) and ma		
	the Ho	ledical	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.		vestigation, in my	opinion, death occ	urred at the time, d	ate and place,	and due to	o the cause(s)
	vitl Con	Σ	29b. Signature and tile of certifier			29c. Licens	66-01/	2	9d. Date signe	d (Month,	uay, rear)
,	6		30. Name and address of person who	completed cause of death (from	n 23a) /Tune	Print)	100716		100		
				SUSATHA K	ZAMAS	LISHAN	99011	MEDICAL	CENT	ERJ	RIVE
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature			~	FVILLE	141	

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Vijay Karumbunathan,

**FER 03 5008** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Census

29c. License number

- 201 Hall Highway - Crisfield, MD

D 48098

29d. Date signed (Month, Day, Year) 2009

Physi /Med Exam

Funera Directo

	Please	Type or Print					-	•			
	1 - For State Registrar	State of Mar			artment of H <i>rtificate of L</i>		ental Hygieı/ . <sub>Reg</sub>		0 01.066		
ian:	1. Decedent's Name (First, Middle, La						2. Date of Death Month	Day Year	3. Time of Death		
ian ical			RADER				FEBRUAR	7 200	9 8:00P M		
iner	4a. Facility Name (If not institution, give		משו			Location of Death		4c. County of De			
	CALVERT CO. NU. 5. Social Security Number 6.5		.ER In yrs. last birt	hday)	PRINCE If Under 1 Year	FREDER I If Under 24 Hrs.	8. Date of Birth	CALVER 9. B	irthplace (State or Foreign		
	234-36-3128 Usual Residence of Decedent	1□M <b>¾</b> ¥F	Hours Min.	(Month, Day, Ye MAY 26,	a <i>r</i> )   (	ST VIRGINIA					
'n	10a. State 10b. County  MD CALVE		0c. City, Town		cation FREDER	CV			10d. Inside City Limits  1∕C√√es 2 □ No		
rect	10e. Street and Number	KI	LKIN	CL	10f. Zip Code	LCK	10a.	Citizen of What 0	Country?		
Funeral Director	85 HOSPITAL RO	AD			20678	3		U.S.			
nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	nerican Indian,		
þ	1 ☐ Never Married ★★Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 25 No If Yes, Give Year or Dates:			1 ☐ Yes <b>X</b> XXNo	Specify:	Hican, etc.)	Black, Wh	HITE		
eted	15. Decedent's E		16a.	(Give	dent's Usual Occupa	lurina most of work	16b	. Kind of Busines	s/Industry		
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	m Er	life. I	DO NOT use retired	)		ס שתבונ	E THERTON		
	17. Father's Name (First, Middle, Las	<u> </u>	1E	T.E.	COMMUNIC		e (First, Middle, Maid	DEPT. O	F INTERIOR		
Be C	JOHN LEE DAV	*					MAE GOO	,	la de la companya de la companya de la companya de la companya de la companya de la companya de la companya de		
2	19a. Informant's Name/Relationship	 (Type. Print)	19b.	Mailin	ng Address (Street a	and Number or Rui	ral Route Number, Ci	ty or Town, State,	Zip Code)		
	PAUL D. QUICKL	E, II/SON	74	00	ROBIN F	ROAD LA	PLATA, N	IARYLAN	D 20646		
	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 [		cemeter	y, cren	sition (Name of matory or other plac CREMATOF	v	TOARI	Location - City o			
	4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lige		MEIKO	-			2009 A	LEXANDR	•		
	How Bot	- (1	100641	56	635 WASH	INGTON	AVE.LA	PLATA.	MD 20646		
cal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last		consequence o	of): of):	notic Co	ardiova	scelar a	diteace	Approximate Interval Between Onset and Death		
edi		- u									
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 l 4 □ Pregnant at tin 9 □ Unknown	Fetal death		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year		
y Ph	Part II. Other significant conditions	contributing to death but r	not resulting in	the ur	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute	to the cause of death?		
q p	Advance	Dement	14				1 ☐ Yes	2 No 3 1	Probably 4 Mnknown		
omplete	Preumonia	>					24a. Was an autopsy performed	ン   death?	autopsy findings available completion of cause of		
Be C	25. Was case referred to medical					26. Place of Deat	1 Yes 2 2 h (Check only one)	No 1 □ Ye	5 2 NO		
	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Out	patien	t 3 DOA Othe	er: 4 Nursing Ho	ome 5 ☐ Residence	6 □Other (Sp	ecity)		
::	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. T	ime of njury	28c. Injun Work	at ?	28d. Describe how in	njury occurred			
Certification: To	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		- At home, far Specify)	M 1 Yes 2 No				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of example and manner states	kamination and	, death	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cause rred at the time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)		
Me	29b. Signature and title of certifier		2NO		29c. License	50653	3 :	Date signed (Mor	2009		
	30. Name and address of person who 5851 - D	completed cause of deal	th (Item 23a) (	Туре,	Print) GYF	N.C.	SURA.	NB N·D	20751		

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Sy

chuschton

32. Registrar's Signature

Road

Deale

20751

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04867 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2009 6:15 P.M February Marlowe Aitha Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 17509 Virginia Ave. Hagerstown Washington 8. Date of Birth (Month, Day, Year)
April 21,1921 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 87 Maryland **Director** 220-46-2474 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Hagerstown Maryland Washington death with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 21740 U.S.A. 17509 Virginia Ave. or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: è 3 Widowed 4 Divorced White 'natural" Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally lnury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 0 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Pearl Shreiner Lowell Howard Taylor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17509 Virginia Ave. Hagerstown, Maryland 21740 (Friend) Carol E. Rhinehart 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State February Hagerstown, Maryland 4 Donation 5 ☐ Other (Specify) 12, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 lee\_ ANIS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** an disease or condition resulting in death) /Medical Due to (pn as e consequence of) Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): so the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or es a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☑No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed r this certificate had rail director, page 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral c 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 2 Medical

Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director: /

		building, etc. (opeany)		Only or 10	wit, otate)
9a. Certifler. (Check only one)	1 Certifying Physic 2 Medical Examine	clan: To the best of my knowledge, death occur: On the basis of examination and/or investig and manner stated.	urred at the time, date and place gation, in my opinion, death occu	e, and due to the rred at the time	e cause(s) and manner as stated. date and place, and due to the cause(s)
9b. Signature and	title of certifier	n MD	29c. License number	1	29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) SIDDI Rey Day, Year) 31 Date filed (Month)

anlietum 87 Hugestona MD2/740 Farke.

			For State of Maryland		rtment of F			,	000	01000
_			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	uncate of	Dealli	2. Date of Dea		009	3. Time of Death
	ysicia Vedic		Anne-Lise Vinten-Johansen				Januar		20 <b>09</b> °	6:58P M
Ex	amin	er	4a. Facility Name (If not institution, give street and number) 10500 Rockville Pike #1602		4b. City, Town, o Rockvi		ith		nty of Death tgomer	У
	eral ctor		5. Social Security Number 6. Sex 7. Age (In yrs. la.	st birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 1914	9. Birthp	place (State or Foreign ntry) imark
D			Usual Residence of Decedent							
Maryla f shov	sid at	lor		Town or Loc $kvill$					11	0d. Inside City Limits  1 Yes 2 No
h the /	motif	Director	10e. Street and Number		10f. Zip Code			l0g. Citizen o	of What Coun	
ath wit	ust b	ral	10500 Rockville Pike #1602		20	852	U1	nited	States	of America
<b>Baltimore, Imaryland 21213-0036</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Examinario	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	В	lace - Americ lack, White, e cify: Cauc	etc.
<b>Z15-0036</b> hin 72 hours aft e. an "natural", or	lical	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup	ation	arkina I	16b. Kind of	Business/Ind	lustry
d within giene.	W We	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ind of work done of NOT use retired	i)	n Killy	En+	ertain	mont
filed A	ent, II	Be Co	12 17. Father's Name (First, Middle, Last)	ватт	erina	18. Mother's Na	me (First, Middle, i			ment
yland  yland  ould be file  Mental Hy arked oth	atic ev	To B	Jens J. A. A. H. Bjarnø			Inger	J. Lund			
, Mar and 2 sho eaith and 127 is ma	er traum		19a. Informant's Name/Relationship (Type. Print)  Dorte Vinten-Johansen - Daught				Rural Route Number 111s Chur			
Saltimore, bermit. Pages 1 ar Department of Hea mportant: If item	or oth				ition (Name of atory or other place			20c. Location	n - City or To	wn, State
ITIM iit. Pagartmen artmen	njury	i	4 □ Donation 5 □ Other (Specify) Ft.  21. Signature of Funeral Souther Licensee				/04/2009			Maryland & Cremation
Dep T	any		21. Signature Publish				ke, Rockv			TAL 200 MILES 174
Physic /Med	_		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Congress Live H.	art F		g, such as cardia	ac or respiratory arr	est,	W	Approximate Interval Between Onset and Death
Exami	ner		Due to (or as a conseque	thmia					Y	ears
cuted	ransit	Examiner	Sequentially list conditions, if any leaf of the form of the cause. Enter Underlying Cause (Disease or injury that initiated events	nos of):					Y	ears
ficate be executed physician and	burial-t	al Ex	resulting in death) Last Due to (or as a consequent	nce of):						
DO/ tificate ig phys	as the	edical	d							
OI VILGI DECOLUS, F.O. BOX O Physician: The law requires that the death certificate has been signed by the attending.	ched for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	eath 3 🗌	Ectopic pregnancy Other (specify)	/			Date of deliver Month	ry Day Year
S, T ss that gned b	e deta	by P	Part II. Other significant conditions contributing to death but not resulti	ng in the und	derlying cause give	en in Part I.	23e. Did tol	acco use co	ntribute to the	e cause of death?
v requires to been signer	should b						1 □ Ye	s 2∭ No	3 ☐ Proba	ably 4 ☐ Unknown
his certificate has b	, page 2 st	Completed					24a. Was a autops perforr 1 □Yes 2	v l	o. Were autop prior to com death? 1 □ Yes	osy findings available inpletion of cause of 2 No
sician sertifi	rector	8	25. Was case referred to medical examiner?  1 ☐ Yes 2 XNo Hospital: 1 ☐ Innation 2 ☐ Es		2 DOA Othe	P.	ath (Check only on			
<b>_</b> O O	era	<u>ا:</u> ک	27. Manner of Death 28a. Date of Injury 2i	8b. Time of	28c. Injury Work	4 🗀 Nursing i	Home 5 X Reside			)
tendin eath. or: Af	the fur	catio	1 ☐ Anatural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury		r res 2 □ No				
Hospital or Attending 44 hours after death. Funeral Director. After	led in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (St. City or Town	reet and Nun , State)	nber or Rural	Route Number,
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: After the Attendin Director: After the Attendin Director of the Attendin Director of the Attendin Director of the Attendin Director of the Attendin Director of the Attendin Director of the Attendin Director of the Attending Director of the Attendi	pletely fil	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowle standard on the basis of examination and manner stated.	edge, death n and/or inve	occurred at the tine estigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time, d	ause(s) and i	manner as sta e, and due to	ated. the cause(s)
20	COO	2	29b. Signature and title of certifier  Touche Weethal	n D	29c. License	number 019785	2	-	uary 2	29, Year)
			30. Name and address of person who completed cause of death (Item 2 Franke Westphal, MD 1201 Sev	3a) (Type, P	rint) cks Road	Suite 2	202, Rock	ville,	MD 208	54
Re	State gistra	_	31. Date filed (Month, Day, Year) 33 Registrar's Signatur School	par	w					

	1 - State of Maryland / State of Maryland /	Certificate of L		, ,		01.00		
Physician /Medical	1. Decedent's Name <i>(First, Middle, Last)</i> Ponfilio Ventresca			2. Date of Death Month February	Day Year y 2, 2009	3. Wime of Death 9:10 a M		
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Silver	Spring If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cour	place (State or Foreign htry)		
	Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow           Maryland         Montgomery         Si	lver Spring		Feb. 9,	1	aly 0d. Inside City Limits 1 □Yes 2 <b>∑</b> ¶No		
natural", or items 23a or 28a-f show dical Extrairment by notified at eted by Funeral Director	10e. Street and Number  11106 Nicholas Drive  11. Marital Status  12. Was Decedent Ever in U.S.		0902		USA  14. Race - Americ			
ural", or iter il Extrairer ed by Fur	1 ☐ Never Married 2 ☑ Married  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 2 ☑ No	Specify:		Black, White, o	nite		
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Extraction must be notified at once.  To Be Completed by Funeral Director	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired,  Mason	ation luring most of worki )	ng 169	b. Kind of Business/Ind  U.S. Gove			
marked oth matic event	17. Father's Name (First, Middle, Last) Ernesto Ventresca		Maria G		Del Monaco			
Item 27 is n	Carmela Ventresca/Wife 1.  20a. Method of Disposition 20b. Place of carmed	o. Mailing Address (Street at 1106 Nicholas of Disposition (Name of ery, crematory or other place	Drive,	Silver Sp		20902		
Important: If any or once.	1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) entombment Gate  21. Signature of Funeral Service Licensee		Cemetery s of Facility Collins	Funeral H	Silver Spri			
tn and id-transit and maiolist and maiolist and maiolist aminer Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	not enter the mode of dying of): Disease				Approximate Interval Between Onset and Death		
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signe be d		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given						
tificate has tor, page 2	25. Was case referred to medical		26. Place of Death	24a. Was an autopsy performed 1 Yes 2 X	prior to cor death?	osy findings available npletion of cause of		
To the Funeral Director: After this cer completely filled in by the funeral direct Medical Certification: To B		utpatient 3 DOA Othe Time of injury M 28c. Injury M 1 Y	at 2 □ No	ne 5  Residence	t and Number or Rura			
the Funeral	29a. Certifier (Check only one)  1  ☐ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the tim nd/or investigation, in my op	e, date and place, a inlon, death occurre	and due to the caus ed at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)		
Com Com	29b. Signature and title of certifier  here certifier  30. Name and address of person who completed cause of death (Item 23a)		number 054378		2 -3 -0 9	Day, Year)		
State Registrar		versity Blvd	l. #400, V	Wheaton,	MD 20902			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 6:05P M Loraine Mahon Vaughn 2009 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home Denton Caroline Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. 1 □ M 2 X F Hours 87 Yrs. Director 078-12-9117 07/25/1921 NY Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits r 28a-f show notified at **Funeral Director** 1X Yes 2 No MD Caroline Greensboro 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 23a must 513 Bernard Ave USA 14. Race - American Indian, 21639 Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Framinance. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **□**X\o Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Horton Mahon Helen St. Mart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joyce Ringgold/daughter</u> 508 Vaughn Ave., Greensboro, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Greensboro Cemetery 02/05/2009 Greensboro, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home 106 W. Sunset Ave., Greensboro, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years **Physician** erebro Vascul /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Day to for as a consequency off Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 □ Pending 1 Tyes 2∏№ after death. investigation 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 29a, Certifier 1 🗠 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year, FER 0 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Mar egistrar's Signatur

**ORIGINAL** 

29c. License number

St. Denton

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien [ ] 19

Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jan. 31, 2009 Year **Physician** 11:58pm Lillian Florence Willman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 15641 National Pike Hagerstown Washington 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Pay Year) 1-27-1916 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 25 F 93 213-68-5957 Yrs. Director Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Washington Hagerstown 1 Yes 2 No Director MD 10f. Zip Code 21740 10g. Citizen of What Country? 10e. Street and Number 15641 National Pike or Items 23a or U.S.A. 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3√2 Widowed 4 □ Divorced Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "I any injury or other traumatic event, the Next residence Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susan Florence Reidel Franklin Howard Morganthall 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15641 National Pike Hagerstown, MD 21740 Marlene Willman Feb. 4, 2009 Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Cem. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) failure -Systolic Congestive **Physician** heart /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Mile of certifier 0058181  $m \triangleright$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anti- tourst . 2 306. 324 E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 4 2009

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jeannette 19, Agnes Webster 5:15 PM January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🙀 F Hours **Director** 577-40-5785 84 13, 1924 Washington, DC Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Extention must anone. 901 Arcola Avenue Funeral 20902 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces' 1 Never Married 2 Married 1 ☐Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Ď Specify: 3 Widowed 4 □ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Binder Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph 2 Tierney Jeannette Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Berniece Sessler / Sister 2012 Meadowbrook Road, Roanoke, VA 24017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Ft. Lincoln Crematory 2/15/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Er er the disea s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line.

Immediate take (Final disease or condition resulting in death)

Processive dementia Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the attending pt IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 Ix No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2X No Division of Vital 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier as stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year) 30

29b. Signature and title of certifier

3. Registrar's Signature Jarke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING

29c. License number

29d. Date signed (Month, Day, Year)

Ashish Tolia,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/NEND#5,9,10qperFH2/1/09,BW,McCo Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Williams 7:10 A M soline Muarcy 27, 2009 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CHOYS 'ommunity Hospital Prince George's anham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Jamaica 6. Sex **Funeral** 1 □ M 2 🖫 F 92 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Wedical Examinar must be notified at Riverdal Director 1 ☐ Yes 2 ☐ No Maryland Prince Jeorge's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 6309 Jamaica 2073 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No or items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify Specify: Blace ≥ 3 Widowed 4 Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If Item 27 is marked other tha any injury or other traumatic Homeowner 6 trivate Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hober Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Riverdale 6309 everle MD 20c. Location - City or Town, State
Jama Ca 20a. Method Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mandiville 107/09 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery lanchester 22. Name and Address of Facility G of Funeral Service Licensee enesis Ctemation And Funeral Siv jarreno DC 20011 Ave. wash 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other included conditions contributing to death but not resulting in the uncertying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2/2/No 3 Probably 4 Unknown page 2 should Be Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 12 No 1 ☐ Yes 1 ☐ Yes 2 🗆 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the within To the and itle of certifie 29b. Signature ٥ 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print) 8118 4008 LUCK RONG LAWHAR ALS

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

**JAN 30** 

Registrar's Signatu

09-01	185
David	Wilson

Vilson		State of Maryla	nd / Departme <i>Certifica</i>	ent of te of	Health and I Death	Mental H	Reg.	No. 20	09 048		
Physicia al Examin	n/ ier	Decedent's Name (First, Middle,Last)  David Lawrence Wilson				- 4	February 9,		3. Time of Death		
	4	4a. Facility Name (if not institution, give street and nur Harford Memorial Hospital	mber)	4	b. City, Town, or Loc Havre De Gra			4c. County of Deat Harford	h .		
Funeral Director		5. Social Security Number 6. Sex 12-70-3220 1X M 2 F	7. Age (In yrs. last birth		If Under 1 Year Months Days	If Under 24Hr Hours Min	s. 8. Date of Birth(	Forei	orthplace (State or gn Pennsylvani country)		
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits			
8	01	Maryland Cecil  10e. Street and Number	Risi	ng S	un 10f. Zip Code		10g	Citizen of What Cou	1 X Yes 2 No		
th the Maryland 23a or 28a-f sho notified at once	声	14 Louise Court	13 Wa	2191		Specify Yes or No-	USA	rican Indian, Black,			
72 hours after death with the Maryland in "natural", or items 23a or 28a-f shi cal Examiner must be notified at once		11. Marital Status         1         Never Married         2         X         Married         1         X         Yes         1         X         Yes         Yes         If Yes, Give Yea         If Yes, Give Yea         Yes         Yes	orces?	If Yo	es, specify Cuban, M	Mexican, Puert	o Rican, etc.)	White, etc.	hite		
2 hours afte "natural" Examine	ted by	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)  College (1	le completed) 16a. I	Deceden	's Usual Occupation ost of working life. D	(Give kind of		6b. Kind of Business	/Industry		
be filed within 7; ntal Hygiene. rked other than ent, the Medical	Completed	11 17. Father's Name (First, Middle, Last)		uipm	ent Opera	tor/Lo	cater ne (First, Middle, Ma	Telep:	none		
uld be filed with Mental Hygiene marked other t c event, the Me	a l	William Elwood Wilson 19a. Informant's Name/Relationship (Type, Print )	195	o. Mailing	Address (Street a		Louise Ke	ppe1 er, City or Town, Stat	e, Zip Code)		
Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. aut: If item 27 is marked other than ' or other traumatic event, the Medical		Barbara Wilson/Wife  20a. Method of Disposition		of Dispos	Box 194 ition (Name of ceme ner place)			D 21911 20c. Location - City of	r Town, State		
it. Pages I rtment of I ortant: If y or other		1 X Burial 2 Cremation 3 Removal fr 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensae	UIII State	view	Cemetery lame and Address o . T. Foard				n, Maryland		
Departminion in jury o		236. Part I. Enter the disease, or complications that of	aused the death. Do no	R 1 ot enter the	.T. Foard  11 S. Que ne mode of dying, su	en St.	Rising or respiratory arres	Sun MD	21911 Approximate Interval		
i I kaminer	1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hyper	tensive ath						Between Onset and Death		
	ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a	consequence of):			39181					
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be executed sician and burial - transit	edical	X UNPENDED AMENDED 23a,27,permE, g888 2/23/09 TT									
h certificate tending phy- use as the b	5	23b. Was decedent pregnant in the	nant at time of death	-	tal death 3 her (Specify)	Ectopic preg	nancy	23d. Date of delive Month	ny Year Day Year		
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The law require icate has been sig page 2 should b	Completed						24a. Was ar autops perforn 1 Yes 2	y prior to ned? death?			
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tal or Attending Physician: The law requires that the salter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactled in by the funeral director, page 2.	유	1 V Yes 2 No 28a. Date	-	outpatien Time of	Injury 28c. Injury	L		Residence 6 Oth	er:		
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To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier (Check only one)  4	st of my knowledge, de	ath occu	rred at the time, dat	e and place, a death occurre	nd due to the cause d at the time, date a	e(s) and manner as st nd place, and due to	ated. the cause(s)		
To the within To the Complete	Medical	29b. Signature and title of certifier	stated.		29c. License O.C.M	number		29d. Date signed (A	Nonth, Day, Year)		
		30. Name and address of person who completed cau Ana Rubio MD. Assistant Medical		Penn	Street, Baltimor		.01				
			egistrar's Signature	. 5,111							

December Share (Part Mode), Late)   Carrolly Review of first institution, you alread and numbers   February   Carrolly Review of first institution, you alread and numbers   Examined   Carrolly Review of first institution, you alread and numbers   Carrolly Review of first institution, you alread and numbers   Carrolly Review of first institution, you alread and numbers   Carrolly Review of first institution, you alread and numbers   Carrolly Review of first institution, you alread and numbers   Carrolly Review of first institution   Carrolly Review of first			for State Registrar	State of Ma	aryland		rtment of H		d Mental H	ygien Reg. N	Z U U	9 048
Part   Part	Physic	ian	1. Decedent's Name (First, Middle, L.	ast)						eath		3. Time of Death
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Physician Medical Examiner    Physician	Dep any onc		1 4 M. 18/10		MOOO				rinsfiel	d Fu	neral H	ome, P.A.
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Due to (or as a consequence of):    Due to (or as a consequence of):			resulting in death)	Due to (or as a				0. 3	105			- C 40
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a	,xammo	<u>-</u> 6	Sequentially list conditions,	b. Due to (or as		(a of):						mandes
IF FEMALE:   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   Month   Day   Year   1   Yes   2   No   3   Probably   4   20   No   4	d	Ē	Cause. Enter Underlying Cause (Disease or injury	Due to (or as	onsequenc	e or).						
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   23d. Date of delivery Month Day Year 1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death 1   Yes 2   No 3   Probably 4   Other significant conditions contributing in the underlying cause given in Pa	e be exectsician and burial-tra	cal Exa	resulting in death) Last						7265			
Type   Type		/ledi	In results	u								
1   Yes   2   No   No   Probably   4   Worker and prior to completion of cause death?   1   Yes   2   No   2   No   3   Probably   4   Worker and prior to completion of cause death?   1   Yes   2   No   1   Yes   2   No   2	the death ce y the attendi ched for use	ysician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at	2 ☐ Fetal dea							,
24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Control of cause death?  25. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Control of cause death?  25. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Control of cause death?  25. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Control of cause death?  26. Place of Death (Check only one)  27. Manner of Death  1   Natural   Natural   Death   Natural   Death   Natural   Death   Natural   Death   Natural   Death   Natural   Death   Dea	s that ined b e deta	Y P	Part II. Other significant conditions	ontributing to death but	t not resulting	g in the und	derlying cause giver	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
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2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of Certifier 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year)	as b	omplet							- auto perfo	psy rmed?	prior to death?	completion of cause or
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	deatl ctor; y the	fical	3 ☐ Suicide 6 ☐ Could not be		v - At home	farm stree		es 2∐No ————	28f Location (	Ctranta	nd Number or D	and David Noveton
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29b. Signature and title of Certifier  29c. License number  29d. Date signed (Month, Day, Year)	in 24 houn he Funera pletely fille	edical	(Check only 2 Medical Exar	niner: On the basis of a	examination :	lge, death and/or inve	occurred at the time estigation, in my op	e, date and pla inion, death o	ace, and due to the curred at the time,	cause(s date an	s) and manner as nd place, and due	s stated. e to the cause(s)
Neb DOALLING	To t	M	29b. Signature and title of certifier			,			785			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Son		30. Name and address of person who	completed cause of dea	ath (Item 23a	) (Type. Pi		0 67	, , ,		chrony	1,2005
	/04		00					4 (	evnard	La lan	~ ~,	20613
			31. Date filed (Month, Day, Year)	32. Registrar	's Signature	,	. 4		- 1/2	, .		
Registrar FEB 4 2003 A. Jacks			4 ZUU	postolina	B. 1	park						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1 - For State Registrar

			- negistrar									Heg. No.	3 5 7			
-81	Dharatai		Decedent's Nam	e (First, Middle, Las	t)						2. Date of De			3. Time of Death		
	Physici		Dorothy					January	y 28 2	2009	1634 M					
14	/Medi		Dorothy Edna Waltz  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of								Januar.					
	Exami	ner	4a. Facility Name (	it not institution, give	street and number)		4					4c. County of Death				
			2309 De	er Park R	<b>b</b> ad			Fink	sburg	1			Carro]	L1		
	Funeral		5. Social Security N	lumber 6. Se	ex 7. Ag	e (In yrs. last b		f Under 1 Year			8. Date of Bir	rth	9 Birthn	lace (State or Foreign		
	Director		216 20 0	FOF 1	□M 2 🔀 🗆	0.4	Yrs. N	lonths Days	Hours	Min.	(Month, Da	th ay, Year) 5 1924	Cour	ntry)		
i.	Director		216-20-0			84					Oct 20	1924		MD		
	Pu .		Usual Residence of			10. 0" T										
	yla at		10a. State	10b. County		10c. City, Tov	wn or Locati	on					1	0d. Inside City Limits		
	Mar fed	호	MD	Carr	o11	F	'inksb	ura						1 ☐ Yes 2 No		
	28a Otif	e C	10e. Street and Nu								I do ou					
	death with the Maryland rms 23a or 28a-f show r must be notifled at	Director	rue. Street and Nu	mper				10f. Zip Code				10g. Citizen of	What Coun	itry?		
	h w 23a st b		2309 Dee	r Park Ro	ad			21048				US	SA			
	ns (mn	e	11. Marital Status		12. Was Decedent	Ever in U.S.	13 Was			igin? (Spor	cify Voc or No		ce - Americ	an Indian		
	iten	Funeral		ind OF Manual	Armed Forces?		If Ye	Decedent of Hes, specify Cuba	an, Mexicai	n, Puerto F	Rican, etc.)	Bla	ck, White,			
98	72 hours after death with the Marylar natural", or items 23a or 28a-f show dical Examiner must be notifled at	by		ied 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	NO	1 🗆	Yes 2⊠No	Specify:			Specia	5			
Maryland 21215-0036	72 hours "natural"; edical Exa	P	3 X Widowed	4 ☐ Divorced	Year or Dates:				res 212 No Specify:				y. Wh	nite		
7	2 h atu ical	Completed	15. Decedent's Education  (Specify only highest grade completed)  16a. Decedent's Usual Occupation  (Give kind of work done during most of w									16b. Kind of E	usiness/Inc	dustry		
47	be filed within 72 h ital Hygiene. id other than "natu event, the Medical	<u>e</u>	(Specify only highest grade completed)  (Give kind of work done during most of work done during								ig .			,		
7	within ene. than " he Mec	Ē	Elementary/Seco	ondary (0-12)	College (1-4or	5+)		Homemak				05.70	. Home			
N	lygie	ပြ						nonemak						<u> </u>		
힏	e filed al Hygi other vent, t	Be	17. Father's Name	(First, Middle, Last)					18. Mothe	er's Name	(First, Middle	, Maiden Surnai	ne)			
<u>0</u>		10 10	James O	rton Dors	ev				M	larga:	aret Shipley					
$\geq$	J M J M nar	F														
<u>a</u>	2 should be n and Mental is marked of raumatic ev	8		ame/Relationship (7	,	19	b. Mailing A	ddress (Street			ral Route Number, City or Town, Sta			Code)		
	artr.		Darlene	Haschert/	daughter		541 H	ook Roa	d We	estmir	nster,	MD 211	.57			
હ	is 1 and 2 should of Health and Mer item 27 is marker other traumatic		20a. Method of Disp	oosition		20b. Place of			1	Da	ate	20c. Location	- City or To	wn State		
ō	it of it of it of or or or or or or or or or or or or or		1 Burial 2	☐Cremation 3 ☐	Removal from State			ory or other plac					•	,		
<u>Ë</u>	Pa ant: ury		4 ☐ Donation	5 Other (Specify	)	Deer	Park	Cemete:	ry	1/31/	/2009	Smallw	rood,	MD		
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fu	meral Service Licen	ee		2 <b>6</b> -N	ime and Addres	se of Facilit	tv Llomo	bac c	hapel,	T) 7\			
ä	permi Depar Impo any ir			0//	1									011==		
			16.5	- m								minster	, MD	21157		
194			23a. Part1. Enter	ne disease, or comp	lications that caused one cause on each li	the death. Do	not enter th	ne mode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate		
	Dhimleton	0.74	Immediate Cause (		nic dauge on each in	ic.								Interval Between		
	Physician		diameter and district			-1.0 -								Onset and Death		
			disease or condition	n	a. CA	0/18	SW							west and Death		
- 20	/Medical		resulting in death)		a CA Due to (or as	O V S		·		12	3. 34.7			ise .		
7	/Medical Examiner		resulting in death)		a. Oue to (or as			0-4-1	N.0	N. A.	- 50	T		iver.		
		Je Je	resulting in death)		a. Due to (or as			السامل	Dv2.	يلار	- Ty	nett		7 Syem		
- P	Examiner	iner	resulting in death)		a. Due to (or as			ا	)r.	ابل	3	nett		> 3yeur		
	Examiner	aminer	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, interdiate rlying injury	a. Due to (or as			L Eudert 1	Dv2.	s.e.	- To	nett		Syeu		
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Division of Vital Records,

DHMH 17 Rev 1/2001

State

Registrar

(Check only one)

31. Date filed (Month Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Year)

Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** MINNIE L. WEST anun 2009 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT STON 1/2M0712 AT EASTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2**X** F Yrs WEST VIRGINIA Director 235-22-1307 27, 1920 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Examinat must be notified Completed by Funeral Director MD TALBOT CORDOVA 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ъ 11678 BLADES ROAD items 23a 21625 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates Specify Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ FRED HURST BEATRICE WEST 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 item 27 is ARTHUR P. KITTS/SON 12334 LEWISTOWN ROAD, CORDOVA, MD 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/9/2009 HILLSBORO, MARYLAND GREENMOUNT CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 CHOL MERCERO Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's POK **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, that the death certificate be Physician/Medical as attending IF FEMALE: asn If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No. 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ≥ icate has been significate has page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 2 **X**No 1 Yes 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 2XER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1/ Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur death. 1 ☐ Yes 2 🗌 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide #Escritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

WAFIK IBRAHIM ZAKI M.D. 920 MARKET ST., DENTON, MD 21629 31. Date filed (Month, Day 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

004

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			For			State of	of Mary	/land /						lental Hy	giene 🤈	nna	01.87	
-			1 - State Registrar Certificate of Death Reg. No.										0401					
	Physici	ian	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month  PTOHADD FLACE LIACON (Control of the Control								Day	Year	3. Time of Death					
10	/Medi		RICHARD ELMER WASHINGTON JANUARY								2009	5:37 PM						
	Examir	ner			_									•		inty of Death		
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	Funeral		5. Social Security N 219-46-6			M 2□ F		n yrs. last b	Yrs.	Months	Days	Hours		8. Date of Birt (Month, Da	y, Year)		place (State or Foreign ntry)	
	Director		Usual Residence of				69	9						JULY 18	1939	WASH	INGTON, DC	
34	land ow		10a. State	10b. County	/		10	c. City, To	wn or Lo	cation			_			1	0d. Inside City Limits	
2	Mary F sh	ţ	MARYLAND CHARLES NANJEMOY										1XYes 2□No					
#168734	death with the Maryland ms 23a or 28a-f show ri, ust be notified at	Director	10e. Street and Nu				- 1	1121110	LITOI	10f. Zip	Code				10g. Citizen	of What Cour	ntry?	
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3 ₹	it. Partme		4 □ Donation				ے اِل	AK GI						7, 2009		MOY, M	ARYLAND	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Expurient is ust be righted at once.			won =	200	2~~	0.0		ן ֓֡֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֟	HÖRN	TON	FUNEI	RAL H	OME, P.	A. III	7.4.D. 3.6T	20640	
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	Physician / /Medical		disease or condition resulting in death)	on	a.		H- 07	HC]	7/-	~ +	ا رل د،	y					0 1	
-	Examiner		Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  That injury that injury that injury that injury that injury are injury.											B 1775				
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Вох	Attending Physician: The law requires that the death certificate is crosalt.  ectos alth.  ectoral Atter this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the the funeral director.	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   1   Live birth 2   Fetal death   5   Other (specify)   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Tetal death   3   Live birth 2   Tetal death   5   Other (specify)   23c. If yes, outcome of pregnancy   1   Live birth 2   Tetal death   1   Live birth 2   Tetal death   1   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2   Live birth 2										23d.	Date of delive	ery			
œ.	death e atte d for	icia												Month	Day Year			
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ď.	s tha	by P	Part II. Other signif	ficant conditi	ons cont	tributing to d	leath but no	t resulting	in the un	derlying c	ause giv	en in Part	I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?	
Ď	w requires t been signe should be													1 □ Y	es 2□No	3 ☐ Prob	ably 4 Unknown	
ပ္တ	law re as bee 2 sho	Set												24a. Was a		b. Were auto	psy findings available	
æ	The law te has age 2 s	Completed												autop:	med2	death?	mpletion of cause of	
Division of Vital Records,	sIclan: The la certificate ha irector, page 2	Be C										I LLI TES	2 🗆 140					
>	ysici is ce direc	70 B	examiner? 1 ☐ Yes 2 【2	No	Ho	ospital:	Inpatient	2   ER/0	utpatien	t 3 🗆 DC	Oth Oth	or:		ne 5∐ Resid		Other (Specif	v)	
0	ding Phys h. After this funeral dir	Ē	27. Manuar of Deat		et.	28a. Date	of Injury	28b.	Time of	2	28c. Injur Worl			28d. Describe h				
. <u>ö</u>	kttendin death. ctor: Af y the fur	atio	1 Natural   5 Pending investigation   2 Accident   3 Suicide   4 Homicide   4 Homicide   4 See. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Num City or Town, State)   5 Pending investigation   M   1 Yes   2 No   1 Yes   2 No   28f. Location (Street and Num City or Town, State)															
<u> </u>	ar de recto by th	iệi l											treet and Nu	mber or Rura	l Route Number,			
Ō	tal or rs afte al Dir led in	Certification:				June	3, 23, 10							-1, 0, 1011	, ,			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only											and due to the				
	To the He within 24 To the Fu complete	Medical	one)			and man	ner stated.								time, date and place, and due to the cause(s)			
	o de time	2	29b. Signature and			1	m/~	1				e number	7-93			ned (Month,		
			P 4.9	174-5-	Ī	CIN	MALIC	~			NO	06-	7 (-	7	FEB	4	2009	

State Registrar

20646

GARRETT C. MARTN, M.D., CIVISTA MEDICAL CENTER, 5 GARRETT AVE., LAPLATA, MD

31. Date filed (Month, Day, Year)

FEB 0 3 2009

Summa B. Sparker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			_ FOr	partment of Health and Nertificate of Death	Mental Hygier Reg. N	7003	04880				
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death				
	Physicia /Medic		BELVA LAVENA WHITE		FEBRUARY	3 2009	12:00 A M				
·	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death					
4			HOMEWOOD RETIREMENT CENTER	WILLIAMSPO		WASHING					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 □ M 2 ☒ F	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea						
	Director		217-12-1615 S8 Yrs. Usual Residence of Decedent		AUG. 28,	1920 M	ARYLAND				
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			Od. Inside City Limits				
	Mary Ff sh	ţo	MARYLAND WASHINGTON	WILLIAMSPORT			1 □ Yes 2 📉 No				
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	ntry?				
	h with	a D	16505 VIRGINIA AVENUE	21795		U.S.A.					
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White,					
99	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No Specify:	7,104.1, 0.0.7	Conneil in					
00	ural",	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:			l MI	HITE				
21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. rd other than "natural", or items 23a or 28a-f show event, I'm Midical Evarance coust by rectified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing 166.	Kind of Business/In	dustry				
112	withii iene. <b>than</b>	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	HOMEMAKER		OWN HO	ME				
	i filed of Hygin	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide						
Maryland	should be f and Mental I s marked of umatic eve	TOBLICE LEE GAVER  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, States									
ar	2 short and fils ma										
	1 and 2 Health tem 27 l		FRANCES B. GLADHILL/DAUGHTER 9804			<u>-</u>					
Baltimore,	6 O		20a. Method of Disposition  1 ☑ BuriaL 2 ☐ Cremation 3 ☐ Removal from State	position (Name of lematory or other place)	Date 20c.	Location - City or To	own, State				
Ε̈́Ξ	permit. Page Department Important: I any Injury o		4 □ Doy ation 5 □ Other (Specify) BOONS BOI	RO CEMETERY 2/06/		ONSBORO,					
3a	permit. Departr Importa any inju		MAIII Paul M Dean		AST-STAUFFI						
	HB = 10 G		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	7606 Old National E		sboro, MD	21713 Approximate				
2			shock, or heart failure. List only one corse on each line.	t topper lu	774		Interval Between				
	Physician /Medical		disease or condition resulting in death)  a.  Die to (or as a consequence of):	Lizari n	1111	- 0	LYM,				
7	Examiner		N. C. C. C. C. C. C. C. C. C. C. C. C. C.	HYXXXXXX							
	D =	Je.	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiate agreements).	(1)							
	ecuted and transi	Examiner	that inhated events								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):								
876	cate I physi the b	dical	d								
9 X	eath certific attending p for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	an.				
Вох	atter for u	ciar	in the past 12 menths?	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year				
P.O.	at the de by the tached	Physician/Me	9 Unknown								
S,	ires that signed I		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to t	he cause of death?				
ord	w require been sign should b	Completed by	[[1 1017045190] PAUK 60801014	$\sim$	1 ☐ Yes	2 No 3 Prol	oably 4 🗌 Unknown				
ecc	law n as be 2 sh	plet			24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of				
<u>=</u>		5			performed? 1 ☐ Yes 2 ☐	death? No 1 ☐ Yes	2 □ No				
Vita	stcian: The certificate rector, pag	B	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)						
of Vital Records,	di isi	유	1 ☐ Yes 2 🕅 No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpati  27. Man or of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing Ho	ome 5 Residence 28d. Describe how in		(y)				
	ding Ph h. After th funeral	흲	1 Natural 5 □ Pending (Month, Day, Year) Injury 2 Accident investigation		20d. Describe now m	ary occurred					
Division	Attending in death. ector: After by the fune	iţica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Street and Number or Rural Route Number,						
Ö	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ire)					
	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.								
	o the	Med	and manner stated.  29b. Signature and the profiler	29c. Licence number	29d. [	Date signed Month,	Day, Year)				
	F > F 0		MEGILY I MACK CAR DIAGO	m ()(26		2/3/9.00	9				
			30. Name and address of person file completed cause of death (Item 23a) (Type	Print) D	(2,1)	71-11	1 /11/				
ك	H-5		(tephale-METZWER, MD)	345 / 12 HUE )	TE10/ 17.	acristoe	er ma				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	bad			l				

lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Per FH G888 2/27/09 III
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JAN 25<sup>Day</sup> **Physician** 200'9 11:45MP HILDE WHITE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2920 Sandwich Drive Waldorf Charles Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Month, Day May 12 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Year) Days Hours Min. 1□M 2√2F May 1925 Germany 1833 83 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examirer must be rediffed at once. 1 ☐ Yes 2 ▼No Directo MD Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20601 United States 2920 Sandwich Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes YNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📆 💥 o Specify: Completed by Specify: White 3X□XVidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Martin Burkhardt ELsa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Brown (Daughter) 204 Jefferis Court, Suffolk, Va 23434 20b. Place of Disposition (Name of cemetery, crematory or other place e b 4, 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery | Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 010 21. Signature of Funeral Service Licensee <u> Alexandria Ferry Road, Clinton, MD 20735</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 7 2/CA /Medical Due to (or as a consequence of); **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at d be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direc determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CHERK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fieldson, M.D. 2068 Crain Hwy, Waldorf, MD 20601 L. Thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2009 Registrar

		-	For State	State of Ma	-		rtment of He ificate of D			giene Reg. No.		
			Registrar  1. Decedent's Name (First, Middle, Las	t)					2. Date of De	ath	2009	3. Time of Death?
	Physicia		Rich	ard Allen Wo	odlee				Month January	Day 29	2009	5:01 aM
market .	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		T	4b. City, Town, or L	ocation of Death	- andarj		County of Death	1
1	LAGIIIII	C1	Washington Adven	tist Hospita	1		Tak	oma Park			Mont	gomery
	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 ☑ M 2 ☐ F  7. Age (In yrs. last birthday)  Months Days Hour						8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign ntry)
и	Director		404-86-9940	XIM 2LIF	52	Yrs.	Working Bays	Hours Min.	April 2			entucky
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	orloca	ation					10d. Inside City Limits
	aryla shov	5	Toa. State		Too. Oity, Town	101 2000						1 □Yes 2 ☑ No
	he M	Director	Maryland Montgo	mery	, <del></del>		Silv 10f. Zip Code	er Spring		10a Citi:	zen of What Cou	ntrv?
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	eath	Funeral	10302 No1cr	12. Was Decedent E	ver in U.S.	13. W		20903 panic Origin? (Spe	ecify Yes or No	)-	14. Race - Ameri	
10	ter d	듄	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No			as Decedent of His Yes, specify Cuban		Rican, etc.)		Black, White,	etc.
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deat Evander nust be multified at	þ	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates:		11	□Yes 2⊠No	Specify:			Specify:	Black
Õ	2 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a.	Decede	ent's Usual Occupat	tion	ina	16b. Kir	nd of Business/Ir	ndustry
21	within 7 iene. • <b>than "r</b>	gu	Elementary/Secondary (0-12)	College (1-4or 5+	)	life. Do	ind of work done du O NOT use retired)	mig most or more	, ig			
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nd	be file	Be	17. Father's Name (First, Middle, Last)				1	18. Mother's Name	,		Surname)	
yla	2 should be and Mental is marked of aumatic ev	၉		tice Woodlee					Eulous			
Maryland	2 sh n and ris m		19a. Informant's Name/Relationship (7	ype. Print)			Address (Street ar					
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Markel Evanting in the Intilian at		Yolanda M. Woodlee 20a. Method of Disposition	- Spouse			Nolcrest D		er Sprin		cyland 209 cation - City or T	
ğ	Pages nent of int: If ite iry or o		1⊠ Burial 2 ☐ Cremation 3 ☒			-	ition (Name of atory or other place)	i .			·	
Baltimore,	it. Partmen		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Green		ows Cemetery Name and Address		5/2009	Loui	sville, K	entucky
Ba	permit. Pag Department Important: I any injury o once.		Myelin T	Webed		Hi 11	nes-Rinaldi 800 New Ham	Funeral H	ome, Inc	ver Sp	oring, Mar	yland 20904
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
-	Physician	i i	Immediate Cause (Final disease or condition	Athero	sclenot	Tic	Coronan	y Arte	ery d	1150	ase	Offset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):		/				
		اپا	Sequentially list conditions, if any, leading to immediate	b	annian and a second	an.					-	
	ted isit	je	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence t	017.						
5	al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of	of):						
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.89	- O M	ledical			*					- 1		
Box	eath certifi attending for use as	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 □	Ectopic pregnancy			1 2	23d. Date of deliv	•
	The law requires that the death cernate has been signed by the attendingage 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Year
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000	w requires s been sign should be	ted									1	
of Vital Records	elaw hast e2s	Completed					······		24a. Was		24b. Were aut prior to o death?	opsy findings available ompletion of cause of
a									1 □ Yes	2 1 1 1	1 □ Yes	2 🗆 No
Ζ	Physician: The I. rthis certificate ha	Be	25. Was case referred to medical examiner?	Hospital:	. 25-010		Other	26. Place of Deat			. I	
	Phys rrthis eral dii	1.70	1 No 2 No 2 No 27; Manner of Death	1 ☐ Inpatie	y 28b. 7	Time of	3 DOA 28c. Injury Work?	4 LI Nursing Ho	me 5 ☐ Hes 28d. Describe		6 ☐ Other (Spec y occurred	iry)
on	Attending Phy is death. ector: After thi by the funeral o	ij	Natural 5 Pending investigation	(Month, Day	Year) I	Injury		es 2□No				
Division	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Place of Inju	ry - At home, fa	rm, stre	et, factory, office	Ĭ	28f. Location (	Street an	d Number or Ru	ral Route Number,
ă	s afte	Certification:	4   Homiciae	building, etc	. (Specify)				City of 10	wii, State	,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the fi	ledical (	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination an	e, death nd/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time	e cause(s) , date and	) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	. 7_1	+11	- 1	29c. License			29d. Dat	te signed (Month	, Day, Year)
	7		> your K	Typtfo	of for	12	523	16			January 29	, 2009
	(		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, P	Print)					
			James K. Lightfoot			entur	y Blvd., Su	ite 200, G	ermantow	n, Mai	ryland 208	374
	Sta Registi		FEB 0 2 200		r's Signature	bar	as.					

		_	For State (	of Maryland / Depa Cer	artment of Health a	and Men	tal Hygien		9 04883		
			Decedent's Name (First, Middle, Last)				Date of Death Month D	ay Year	3. Time of Death		
niti.	Physicia /Medic		LEROY L. WOODARI	)			AN. 26		1:10 PM		
	Examin		4a. Fecility Name (If not institution, give street and no		4b. City, Town, or Location of	of Death	4	c. County of Dea	th		
			Arcola Healh& Rehal		Silver Spr		No. of Dias	MONTGO			
	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age (In yrs. last birthday) 84 Yrs.	Months Days Hours	Min. (	Date of Birth Month, Day, Yea ept.6,	1024 1	thplace (State or Foreign puntry)  Vash DC		
		ŀ	Usual Residence of Decedent	04			ерс.б,	1924 1	dsii. DC		
	ryland thow		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits		
	Ba-f s	Director	MD Montgomery	Brook	eville				1 √Yes 2 No		
	vith th	Dire	10e. Street and Number		10f. Zip Code		10g. C	itizen of What C	•		
	death with the Maryland ms 23a or 28a-f show Linust be notified at	era	19116 Holberton  11. Marital Status 12. Was Dec	cedent Ever in U.S. 13.1	20833 Was Decedent of Hispanic Orif Yes, specify Cuban, Mexican	inin? (Spacify)	Vas or No-	U.S.			
	tter d	Funeral	Armed F	n, Puerto Ricai	n, etc.)	Black, Whi	te, etc.				
3	urs a	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, G  X☐ Widowed 4 ☐ Divorced Year or I			Specify: B]	.ack				
9500-61212	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or liems 23s or 28s-f show svent, the Marilical Examiliar must be mailled at	Completed	15. Decedent's Education (Specify only highest grade completed	) (Give	dent's Usual Occupation kind of work done during mos. DO NOT use retired	t of working	16b.	Kind of Business	/Industry		
7	within ene. then	m jd m	Elementary/Secondary (0-12) College								
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	yrs Bů		ector	Sta st, Middle, Maide		Maryland		
and	d be f antal h	) Be	William Woodard	isy W		in Juniano,					
>	d 2 should th and Men 7 is marke traumatic	ဥ	19a. Informant's Name/Relationship (Type, Print)		. T.E.  Number, City or Town, State, Zip Code)						
Mar	12 ha		Fannie M. Bosier (S	, NW,	Washir	ngton,I	C 20001				
saltimore,	- 표 등 및		20a. Method of Disposition	20b. Place of Dispo		Date		Location - City or			
Ĕ	Peges nent of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		n Mem Cem	2/2/0	9 Ro	ckvill	e. MD		
ğ	permit. Peg Department Important: I sny injury o		21. Sign turn of Funeral Service Lic of ee	11. 11/2011	. Name and Address of Facilit	y SNO	WDEN FU	JNERAL	HOME, P.A.		
ш	20E#3		/way	77	46 N. Washi			ckville	<u> </u>		
			26a. Part1. Enter the disease, or complications that shock, or heertrailure. List only one cause on	caused the death/Do not ent each line.	er the mode of dying, such as	cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death		
	Pnysician /Medical		resulting in death)	oronary Arte	ry Disease						
	Examiner		Due to	(or as a consequence of):							
l'd		er	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a nonsequence of):							
	outed id ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events								
Ď,	en ar	Ex	resulting in death) Last Due to								
8/60	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dlcal	d								
Q X	entific ding p	Med	IF FEMALE:								
XOX	eath certific attending p	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
л О	at the de by the a tached	yslo	1 Yes 2 No 4 Fleg 9 Unknown 9 Unk		Other (specify)						
	res that igned b	by Pi	Part II. Other significant conditions contributing to		23e. Did tobacco	use contribute t	te to the cause of death?				
<u>5</u>	w require been sig should b	ed b	Parkinson's Disea	ise			1 🗆 Yes	2 □ No 3 □ P	robably 4-Unknown		
ပ္က	law re	Completed					24a. Was an		utopsy findings available		
ř	The ate h page	Com					autopsy performed? 1□Yes 2\\\	death?	completion of cause of		
Vital Records,	Physician: The rist certificate ral director, pag	Be (	25. Was case referred to medical examiner?		26. Place	of Death (Ch					
	Physic this c	2		Inpatient 2 ER/Outpatien		-	5 Residence		ecity)		
ב	of fe	tlon	- Qualitation of Distriction	of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐		Describe how inj	ury occurred			
Division of	uttendil death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At home, farm, str			ocation (Street	and Number or F	ural Route Number,		
2	after after Dire	Certification:	4 Homicide determined built	ding, etc. (Specify)	oon, radially, direct		City or Town, Sta				
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier  (Check only 2 Medical Examiner: On the	ne best of my knowledge, death	occurred at the time, date an	nd place, and o	due to the cause(	s) and manner a	s stated.		
	the Hin 24 the Fi	ledical	one) and ma	nner stated.		in occurred at					
	With To Con	Σ	29b. Signature and tutler of certifier		29c. License number			ate signed (Mon			
	6		- flousi	XXVIans	D56691			L/26/09			
			30. Name and address of person who completed cause of death (Item 23a) Charles Print)  20906  Ghousia Sultana, M.D. 12107 Heritage Park Cir, Silver Spring, MD								
	Sta	te	31. Date filed (Month, Day, Year) 32,	Registrar's Signature		v CIL	, STIVE	r phij	ing , MD		
	Regist			heur B. for	wed						
			The state of the s								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Murray /Medical Wollstein January 30, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 800 Hillsboro Drive Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ M 2□ F Months Days Hours Director 578 36 8806 90 10/18/1918 New York 10a. State ıral", or items 23a or 28a-f show I Examiner must be notifled at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 10g. Citizen of What Country? 800 Hillsboro Drive Funeral 20902 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Self Employed **Grocery Store** other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h ပ Isadore Wollstein Dinah Berger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar If Item 27 Frank L. Wollstein/ Son 807 Anne S.W. Leesburg, Virginia 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. ö 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Gdns 2/1/2009 Falls Church, Virginia 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician /Medical METASTATIC disease or condition resulting in death) PROSTATE < ANCETE MONTH Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed inding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month ed by the a 5 ☐ Other (specify) 1 Yes 2 No Day Year 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) P 1 ☐ Yes 21-No Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manno Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Hospital or Attending 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 9834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAKRY M. ROSENIBADM 3720 FARRAGUT AVE KEN SINGTON, MI) 20891 State 31. Date filed (Month; Day, Year) Registrar's Signature 02 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 11:00 P.M JAN. 30, Fredrick Lauriston Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1**X** M 2□ F 579-36-5122 Director 78 JUL. 19, 1930 Washington, DC Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 6121 Montrose Road #409 filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: ukn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4X Divorced Black "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ould be filed w...
d Mental Hygiene."r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jazz Musician / Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic ever James Kelsey Williams Blanche Harris 2 Pages 1 and 2 should and 2 sho.
of Health and Me
at: If item 27 is re 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $7413\ Blair\ Road\ NW$  Washington, DC 2001219a. Informant's Name/Relationship (Type. Print) Joy P. Williams, Former Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FEB. 3, permit. Page Department of Important: If any injury or Atlantic Crematory Glen Burnie, Maryland 2009 22, Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL, Silver Spring, MD 20910 21. Signature of Funeral Service Licensee m The M01508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 DAYS Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 DEMENTIA, CHRONIC KIDNEY DISEASE STAGE 5 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐Yes 2 X No Vital 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 ∏ Natural 2 ☐ Accident Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at Jo the Funeral D 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. rpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38262 JAN. 31, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., ANURITA MENDHIRATTA, 2401 RESEARCH BLVD., SUITE 330, ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FER 02 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ralph Welsh D. 28, 3:45 January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 401 Beaglin Park Drive Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1**X** M 2 □ F 95 220-10-9968 12/22/1913 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I as the clean Exv. virus must bor calling an any Injury or other traumatic event, I as the clean Exv. virus must bor calling a Director Maryland Wicomico 1 X Yes 2 □ No Salisbury 10f. Zip Code 21804 10g. Citizen of What Country? 10e. Street and Number 401 Beaglin Park Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 No
If Yes, Give
Year or Dates: Army 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 Nidowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maintenance engineer Dresser Wayne Industries 17. Father's Name (First, Middle, Last)
Denwood Welsh 18. Mother's Name (First, Middle, Maiden Surname)

Iva Pearl Twilley Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Welsh/son 12308 Backus Dr., Bowie, MD 20720 20b. Place of Disposition (Name of Wicomico Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/31/09 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licens 501 Snow Hill Rd., Salisbury, MD 21804 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anneavemon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24*a*. Was an has autopsy performed?
Yes 2 No certificate 1 ☐ Yes 2 No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Many er of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Amend Item 8 per In, g898 Pepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2 for State Registrar Reg. No. 20 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death CHRISTINE **GODFREY** WHALEY Month Year **Physician** February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 544354724 NICSMICE REGIONAL TENINSUM MEDICAL Centy 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/24/1951 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Country)
Delaware 1 □ M 2 😿 F 57 221-36-6441 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Dagsboro Director DE Sussex 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 19939 34804 Carriage Ct. Funeral within 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ੬ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Purdue Farm Marketing Service Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be es 1 and 2 should be fi of Health and Mental F fitem 27 is marked ot Preston E. Godfrey Sr. Hilda Parker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Henrys Mill Drive Kimberly King Daughter Berlin Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 2/7/09 Delmar, Delaware 19940 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Moo 268 Watson Funeral Home MILLSBORO, De. 19966 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Brewt Cancer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ò 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has certificate 1 □Yes 2 000 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 No 1 🔲 Inpatient 2 FR/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year) certitie H50497 2609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sallshy, MD Smyder 100 E Carroll St. hris 0. 31. Date filed (Month, Day, egistrar's Signatur State Registrar

10 KM 17 Rev 1/2001

ecords, P.O. law requires that the de as been signed by the 2 should be detached
Physician/Medical Examiner
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition
b. Due to (or as d
2 ☐ Fetal death at time of death
): ): 3 □ Ectopic pregnan 5 □ Other (specify) □
2
3d. Date of deliv
ery Day Year

To the Hospita within 24 hours To the Funeral completely filler

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Kohro 31. Date filed (Month, Day, Year)

State Registrar

WES 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician 2009<sup>ar</sup> February Harry Lee Whittington 10:45 AMM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Glade Valley Nursing and Rehabiliation Center Frederick Walkersville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug • 10, 1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 🔀 M 2 🗆 F √irginia 215-18-2692 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location ir than "natural", or items 23a or 28a-f show Frederick 1 ☐ Yes 2X No Frederick Director Maryland 10f. Zip Cod€ 10g. Citizen of What Country? 10e. Street and Number U.S.A. 5017 Teen Barnes Road 21703 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Date \$ 942-1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit, Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Evan 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Quarry/Lime Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Elizabeth Burke Lewellyn Laython Whittington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5017 Teen Barnes Road, Frederick, MD 21703 wife Mrs. Annabelle Whittington, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Resthaven Mem. Gardens Feb. 11, 2009 Frederick, MD 4 □ Donation 5 □ Other (Specify) 21. Signature x Fun ral Service Licensee <sup>22</sup> Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) □Yes 2□No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2. No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural I Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D the Hospital 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and

30 Nameland ac

Date filed (Month, Day,

tle of certifie

Year)

DHMH 17 Rev 1/2001

mpleted gause of death (Item 23a) (Type,

Registrar's Signature

February 9, 2009

			101	artment of Health and Mer	ntal Hygien	0000 01000					
	Physici		1. Decedent's Name (First, Middle, Last) Earl Leon Yeakle		Date of Death Month Danuary						
1	/Medio Examir		4a. Facility Name (If not institution, give street and number) 13 North Martin St.	4b. City, Town, or Location of Death Clear Spring		C. County of Death Washington					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-28-0403 X M 2 F 79 Yrs.	If Under 1 Year   If Under 24 Hrs.   8.	Date of Birth (Month, Day, Year 10-23-1	9. Birthplace (State or Foreign Country) MD					
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le MD Washington Clear S			10d. Inside City Limits 1√□ Yes 2 □ No					
	with the I	i Director	10e. Street and Number 13 North Martin St.	10f. Zip Code 21722	-	itizen of What Country?					
980	172 hours after death with the Maryland "natural", or Iteme 23a or 28e-1 ehow Idical Examinat must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifit of the specify Cuban, Mexican, Puerto Rice of the specify:     □ Yes 2 No Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
21215-0036	within ene. than "	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) achinest		Kind of Business/Industry ruck mfg.					
Maryland	should be filed and Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Benjamin H. Yeakle	18. Mother's Name (F Julia K	irst, Middle, Maide • Eiche						
	17 tra	1 3	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C P.O.BOX 653 Clear Spring, MD 21722								
Baltimore,	oth oth		4 Donation 5 Other (Specify)	position (Name of matory or other place)  Rose Hill Feb. 2	, 20c. L	ocation - City or Town, State ear Spring, MD					
Balt	permit. Page Department of Important: If any injury or		21. Signature 1 Funeral Service License 2:	2. Name and Address of Facility Donald Edwin Tho P.O.BOX 310 Clea	mpson F r Sprin	uneral Home,Inc					
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause or each line.	ter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death					
8760,	/Medical Examiner  physician and the burial-transit	edicai Examîner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of).  Due to (or as a consequence of).  Due to (or as a consequence of).	tenosis acting disea	se.	10 7 2005					
P.O. Box 68	ath certifi ittending or use as	by Physician/M		∃Ectopic pregnancy ∃ Other (specify)		23d. Date of delivery Month Day Year					
	w requires that the de been signed by the a should be detached f		by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death? □ No 3 □ Probably 4 ☑ Unknown				
Division of Vital Records,	The farate has	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  □ 1 □ Yes 2 ☑ No					
Zii.	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examinar?  Hospital: Hospital:	26. Place of Death C							
ion of	ng ftei ine	$\vdash$	1  Yes 2  Accident	IL 3 DOA 4 Nursing Home	5 Residence  I. Describe how inju	6  ☐ Other (Specify)  Iny occurred					
Divis	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	nd Number or Rural Route Number, e)							
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to to Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.							
	vithir To th	M	29b. Signature and title of certifier  Marzen 9 Hrap	vestigation, in my opinion, death occurred a 29c. License number  D 283 65  Print)  Street 1 agents	29d. Da	ate signed (Month, Day, Year)					
É	1-8+1		30. Name and address of person who completed cause of death (Item 23a) (Type, MAN 2AL. SIVA FL 368 WILL	Print) Street 1+agente	au ra	p 21740					
7 20 4 4	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 3 2009	bake							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 Constance Tina Zeender January 30, 10:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 24, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min. Vear 1 □ M 2 🖾 F Months Yrs. 89 Director 577-10-2248 1919 Washington, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Evanimer must be notified at 1 ☐ Yes 2 No Director MDMontgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8310 Woodhaven Blvd. 20817 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ Specify: 3 ♥ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 6 Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Giuseppe Merando Maria Maggio Frini other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health au
Important: If item 27 is in Roger Zeender/son 8495 Reservoir Road Fulton, MD 20759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arundel Crematory 02/04/09 Odenton, MD Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure 12 months disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-1 Due to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a be detached for g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No autopsy page certificate 2 📈 lo 1 □ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical (Check only one) To the within 2

10 E.G.

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title

Thomas/E. Dooley, M.D. 17904 Georgia Ave. Suite 304 Olney, MD 20832

ddress of person who completed cause of death (Item 23a) (Type, Print)

32.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 200004893 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gary Alan Anderson Ebruary 16th 200 6:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Randallstown Seasons Hospice @ Northwest Hospital 8. Date of Birth (Month, Day, Year) າດ 1952 <u>Baltimore</u> 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number **Funeral** 1**X** M 2□ F Months Days Hours Min 218-52-4669 56 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Modical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3716 Buckingham Road **USA** Be Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death \( \)
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23; amy injury or other traumatic event, It \( \) Wellca \( \) Framiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1970 1 Mayes 2 □ No If Yes, Give Year or Dates: 1976 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laundry Service Machine Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson B. Anderson Elizabeth Stetter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Marie Anderson, Wife 3716 Buckingham Road Gwynn Oak, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/17/09 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Juneral Service Linessee Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure: List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TERMINA LVNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No autopsy performed? Yes 2 No certificate 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 📓 Natural 5 ☐ Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 1445931 30. Name and address of pe completed cause of death (Item 23a) (Type, Print) Smith Avenue Baltimare MD 21208 2835 31. Date filed (Month, Day, 32. Redistrar's Signature State Registrar

DHMH 17 Rev 1/2001

# Baltimore. Maryland 21215-0036

Box 68760. Division of Vital Records, P.O.

		Please Type or Pri	aryland / Dep	artment of H	lealth and M	-		9 04894		
		Registrar	Ce	rtificate of I	Death		eg. No.	3 0 1 0 3 1		
Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dear Month	Day Ye	3. Time of Death		
/Medic		Howard Nelson Alice  4a. Facility Name (If not institution, give street and number)	nburg	4b. City. Town, or	r Location of Death	Februar	y 19, 200			
Examin	er			Middle I			Baltimo			
Funeral			je (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	0	Birthplace (State or Foreign Country)		
Director		215-24-5117 <sup>1∑M 2□ F</sup>	79 Yrs.	Months Buyo	110010	8/17/19	29 1	Maryland		
and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits		
Maryl -f sho	to	Maryland Baltimore	Middle R	ivor				1 □Yes 2 <b>X</b> No		
filed within 72 hours after death with the Maryland Hygiene. Hygiene, than "natural", or items 23a or 28a-f show ent, the MacReal Examiner mast be retified at	Director	10e. Street and Number	rituate K.	10f. Zip Code		1	0g. Citizen of Wha	t Country?		
th with		6862 Ebenezer Road		21220			U. S. A.			
r dea	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.		
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be filed within 72 ho ital Hygiene d other than "natui event, The Modical	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, i	Maiden Surname)			
should be and Mental s marked o	ျှ	Robert Altenburg	10. 11.			ae Blic		. 7.011		
d 2 th 8 7 th		19a. Informant's Name/Relationship (Type. Print)		Chomles (Street						
Hear Hear then		Howard Mark Altenburg (Son 20a. Method of Disposition		Cherlyn I cosition (Name of ematory or other place			rland 2122 20c. Location - City			
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			i i	/2000	Daltiman	Manusland		
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	2	e Cemeter 22. Name and Addre	ss of Facility			e, Maryland		
e a E a a		Michael C. Jakhe	N. 5%	Bruzdzinsl 1407 Old I	kı Funera. Eastern Av	I HOME I venue I	'A Ssex, Mai	cyland 21221		
		23a. Part 1. Enter the disease, or complication that cause shock, or heart failure. List only one cause on each I	d the death. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory are	est,	Approximate Interval Between		
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icate be physicia s the bur	ical	d								
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Med	IF FEMALE:								
eath certific attending p	Physician/Medical	23b. Was decedent pregnant 1 Live birth	2 Fetal death 3	☐ Ectopic pregnand	:y		23d. Date of Month			
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Month Day Year						
w requires that the d		Part II. Other significant conditions contributing to death I	out not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?		
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law red as bee 2 shou	olete					24a. Was a	n 24b. Wer	e autopsy findings available		
The la	Completed					autop: perfor 1 ☐ Yes	med? deat	r to completion of cause of th? Yes 2 □ No		
sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Deat					
Physic this o	은	1 Yes 2X No Hospital: 1 ☐ Inpat	ent 2 ER/Outpatie		4 🗆 Nursing no		ence 6 Other (	Specify)		
ding Ph. h. After thi funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, Discourse) (Month, Discourse)	ury 28b. Time ay, Year) Injury	Wor		28d. Describe h	ow injury occurred			
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Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p.		29a. Certifier 1 Certifying Physician: To the best								
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 ☐ Medical Examiner: On the basis and manner s		investigation, in my o	opinion, death occur	red at the time, o	late and place, and	que to the cause(s)		
To t To t	Σ	29b. Signature and title of certifier		29c. Licens	se number	2	29d. Date signed (M	fonth, Day, Year)		
1.1		I Chille 146		000	5+021		419	109		
6+1		30. Name and address of person who completed cause of	death (Item 23a) (Type	, Print)	d. P	SLA	Inc. D	مرداد رتا ۱۱		
Sta	to	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	1/4 all	min od	. UTC	100 15a	17/11 423+		
Sta Registr		FEB 1 9 2009 2	J. A80	akad a						
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

			1 - For State Registrar	State of	Marylar			t of Hea e of De		d Mental H	/giene Reg. No.	2009	3 04	895	
	Physici	an	Decedent's Name (First, Middle,	· .						2. Date of D Month	Day	Year	3. Time	of Death	
Marin.	/Medic	al	ERMA	М.	ADAMS		T			Februar	16,	2009	1:50	a <sup>M</sup>	
	Examin	er	4a. Facility Name (If not institution, Glen Burnie Health a			enter		Town, or Lo .en Buri		eath		County of Dea Anne Arui			
	Funeral				7. Age (In yrs.		If Under	1 Year   If	Under 24	Hrs. 8. Date of B		9. Bir	thplace (State	or Foreign	
	Director		215-28-2606	1 □ M 2 <b>K</b> F	76	Yrs.	Months	Days F	Hours I	Min. 8. Date of B (Month, D July 7,	ay, Year) 1932	Mar	yland		
	pu w		Usual Residence of Decedent  10a. State 10b. County		100 0	ty, Town or Lo	ontion						101 (:1-	Die al inste	
	f short	ō	Maryland Anne A	rundel	100. 01	Pasader							10d. Inside	s 2 K No	
	the N	Director	10e. Street and Number				10f. Zip	Code			10a. Citiz	en of What Co			
	should be filed within 72 hours after death with the Maryland nd Menial Hyglene. marked other than "natural", or items 23a or 28a-f show matic event, the Modical Examinar mant be notified at	iQ le	849 Deering Road					211	L22		-	U.S.A.			
	death	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Deced	ent of Hispa	anic Origin	? (Specify Ye's or N uerto Rican, etc.)	0- 1	4. Race - Ame			
36	after or ite		1 Never Married 2 Marrie		2 🌠 No		irres,spec 1∐Yes 2	4 .	Specify:	uerto nicari, etc.)		Black, White Specify: Wh	e, etc. uite		
Ö	hours ural"	ed by	3 M Widowed 4 □ Divorced	Year or Da	ites:							Specify.			
2	n 72 n "nat	olete	15. Decedent's (Specify only highest	(Give	dent's Usua kind of wor DO NOT us	ıl Occupatio k done durir e retired)	n ng most of	working	16b. Kin	d of Business/	Industry				
212	l withi	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		Homema					Own Home			
ğ	al Hyg othe vent,	Be Completed	17. Father's Name (First, Middle, La	ist)	<del></del>			18	. Mother's	Name (First, Middle	, Maiden S	Surname)			
<u>X</u>	should be and Mental a marked o umatic ev	2	Herman A.	Horz Sr.					Eliza	beth	I. W	hitmore			
Baltimore, Maryland 21215-0036	2 s lalis rau		19a. Informant's Name/Relationship  Donald W. Adam	4 -						r Rural Route Numi			Zip Code)		
e,	1 and Healt em 2 ther		20a. Method of Disposition	5 (301)	205 1	Place of Dispo			ane, A	urora, Illi			Ta Otata		
ğ	9 ± ± 5		1 Burial 2 ☐ Cremation 3		(	cemetery, cren n Haven	natorv`or ot	her place)	-k 102-			ation - City or urnie, M			
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e E	permit. Departr Importa any inju		The Control (	The second	rush	MC 32	Cully-	Polynia	k Fune	eral Home P. asadena, Ma	A.	21122			
			23 art1. Enter the disease, or co shock, or heart failure. List or	omplications that ca	used the deat	h. Do not ent	er the mode	of dying, s	such as car	diac or respiratory	rrest,	21122	Approxima Interval Be	te	
1	Physician		In mediate Cause (Final disease or condition	lly one cause	5PIR	17012	4 1	411	Un	5			Onset and	Death	
2	/Medical		resulting in death)	a. Due to	or as a conseq	uence of):	17	/ 5/ -	, , -						
	Examiner	_	Sequentially list conditions.	b	vell	mon	11/	WI	TH	Pitur	AL EFFIXSION				
	ted isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									FASE			
	execu and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):												
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9	tificat ng phy as the	ledic			- marriage (						- Partie				
X R R	th certific ending p	J/VE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregna		Ectopic pr	oananov			23	3d. Date of del	ivery		
_•	e death he atten	sici	in the past 12 months? 1 □ Yes 2 <b>X</b> No		ant at time of o		Other (spe					Month	Day	Year	
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က်	ires the signer of the displaying th	ক্র	Part II. Other significant condition:	THM	POI	uiting in the ur	nderlying ca	use given ir	n Part I.		obacco us Yes 2 🛂	e contribute to	the cause of obably 4□		
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פ	g Ph ter thi	Ë	27. Manner of Beath	28a. Date o		28b. Time of		Bc. Injury at Work?		28d. Describe			ony)		
101	endin ath. or: Af he fur	Certification:	1	ion	, Day, Ieal)	Hijury	М		2 🗆 No						
NIVISI	r Atter de irecto	ţį	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of buildin	of Injury - At ho g, etc. (Specif	ome, farm, stre	eet, factory,	office		28f. Location (	Street and	Number or Ru	ral Route Nur	nber,	
2	urs af														
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death within 24 hours after death to To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying (Check only one)  1 Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	wledge, death tion and/or in	occurred a vestigation,	at the time, o in my opinio	date and p on, death o	lace, and due to the occurred at the time.	cause(s) a date and p	and manner as place, and due	stated. to the cause(	s)	
	o the	Mec	29b. Signature and title of certifier	and mann	er stated.		29c.	License nu	ımber		29d. Date	signed (Month	Dav. Year)		
<b>.</b>	->-0		Dan 12 Co	ON THE	UM	9812	2	72	1.00	26 A	Pon	0011	16 .0.	500	
ſ	1	ŀ	30 Name and address of person wh	o completed cause	of death (Iten	n 23a) (Type, I	Print)		-/-	7 0	· NOU!	my !	0 /60	vy	
1	+ 1		3721 POT	ED 5	7. P	ALTI	mo	Rt.	Me	ARGUAN.	0,0	2122	5		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture	1								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04896 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:45 P <sup>M</sup> ROSCOE C. ALEXANDER, JR. 15, FEBRUARY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FUTURECARE OF PINEVIEW CLINTON 5. Social Security Number If Under 1 Year\_ If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Deys Hours Min. 1 X M 2 □ F Yrs Director 578-34-3549 8, 1929 DC 80 FEB. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 USA 12209 OLD COLONY DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 V Yes 2 If Yes, Give <sup>2</sup>□N∘8/1953 1 ☐ Yes 2 X No Specify: ģ Specify: 3 Widowed 4 Divorced Year or Dates: BLACK 5/1955 Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PERSONNEL SPECIALIST NATIONAL PARK SERVICE 4+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည ROSCOE C. ALEXANDER, SR. OLGA WASHINGTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once. GWENDOLYN ALEXANDER / WIFE 12209 OLD COLONY DRIVE UPPER MARLBORO, MD 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-23-2009 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM VETERANS CHELTENHAM, MD 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND, RD SUITLAND, MD 23a. Part 1 Enter the disease, or com, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **DEMENTIA** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 💢 No 2 No 1 □ Yes 1 🖾 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Hospital or Attending 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) onel and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D050545 FEBRUARY 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEW HAMPSHIRE AVENUE 20906 TAKOMA PARK, MD OKOJI 7513 GODSWILL 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Chathan B Registrar

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

09-01206	
Cory L. Adams	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce.	rtificate of		ia woman n	U	J. No. 2	009 04	89
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last)	7				2. Date of Death Month February 1		3. Time of Death 0853 hrs	
neulcai Examin	e	Cory L.  4a. Facility Name (if not institution, give st	Adams		4b. City, Town, o	or Location of Death	February 1	0, 2009 4c. County of		
		6441 Washington Boulevard			Elkridge			Howard		
Funeral	T	5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye		-	, 1	Birthplace (State or Foreign	
Director		unknown <sub>1</sub> X <sub>M</sub>	<sub>2</sub> <sub>F</sub> 38	Yrs		ys Hours Will.	Oct.4	,1970	Country) MD	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Locat	tion				10d. Inside City Li	mits
* .		MD Baltimo			sex				1 Yes 2	
Maryland 28a-f show 1 at once.	흸	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?	e
the Man or 2	Director	1400 Browning	Drive		2122	21		USA		
MD 21215-0036 4 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she tumatic event, the Medical Examiner must be notified at once	era		2. Was Decedent Ever in U Armed Forces?			ispanic Origin? ( Sp in, Mexican, Puerto			American Indian, Black,	
r deatl	Funeral	1 X Never Married 2 Married 1	Yes 2x No				rtiouri, oto.			
rs afte ural", míner	۾	Widowed 4 Divorced If Your 15. Decedent's Education (Specify only h	Dates:	1 16a Deceden		o specify: ation (Give kind of w	ork done	Specity: 16b. Kind of Busi	Black	
2 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			e. DO NOT use retir		TOD. TWILD OF EACH		
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2 21215-0036 hould be filed within 72 hours afte nd Mental Hygiene. is marked other than "natural", vite event, the Medical Examine		17. Father's Name (First, Middle, Last)				18.Mother's Name	•	aiden Surname)		
2121 2121 2uld be 3 3 Mental marke ic event	o Be	Carl Adams  19a. Informant's Name/Relationship (Type	Print \	19h Mailine	n Address (Stre	Iola :		per City or Town	State Zin Code)	
ages I and 2 shount of Health and N. t: If item 27 is not other traumatic	۲	Carla Adams (si	. ,			ng Driv		•	. ,	
e e = 9	-	20a. Method of Disposition		Place of Dispos	sition (Name of co	emetery,	Date	20c. Location - C	City or Town, State	
Baltimore, permit Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation 3 4 Denation 5 Other Specify:	Removal from State Gr	een Mo	ount Cr	emaťeb.	18,200	Balto,	Md.	
Baltimo permit Page Department Important: injury or ott	1	21. ature of Funeral Service Licensee	11/1			ss of Facility Scrugo				-
	_	23a. Part I. Enter the disease, or complica	Mugh	14	12 F	Preston	St. Ba	ilto, M	Id. 21213	
Physician /Medical	ľ	failure. List only one cause on each l	ine.	. Do not enter t	the mode of dying	g, such as cardiac of	respiratory arres	st, snock, or near	Approximate Intel Between Onset	
'xaminer	ĺ		pothermia to (or as a consequence o	of):			1-4-6		Deatil	- 0
		Sequentially list conditions, b.	(**************************************							
	<u>  ë</u>		to (or as a consequence of	of):						
_ #	Examiner	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequence o	of):						
and and	<b>—</b> I	d	739 77	78a=f	nermF	g889 3/6,	/ሰዐ ጥጥ			
a a a	Medica	<b>A</b>	WILINDED		perms,					
8760, ifficate being physic as the bur		23b. Was decedent pregnant in the	23c. If yes, outcome of preg		etal death 3	Ectopic pregna	ncy	23d. Date of d Month	elivery Year	
Box 687 death certific the attending p	sician	past 12 months?	Pregnant at time of de		ther (Specify)		•	1	·	
that the deaned by the a	Phy	Part II. Other significant conditions con		naultina in the I	undorluing agus	given in Port I	23e Did toh	pacco use contrib	ute to the cause of death?	2
P.O.	ò	Fattil. Other significant conditions	intibuting to death but not i	esulting in the c	underlying cause	given in Fait i.			Probably 4 V Unknow	
ords, P.C. w requires that is been signed 1 should be deta	Completed		•				24a. Was a		ere autopsy findings avail	
of Vital Records, ag Physician: The law require ther this certificate has been si neral director, page 2 should be	ם						autops perforr	ned? de	or to completion of cause ath?	
tal Rection: The certificate ector, page		25. Was case referred to medical			26 Plac	ce of Death (Check of	1 Yes 2	No 1	Yes 2 No	,
Vita ysiciar his cer directo	o Be		pital: 1 Inpatient 2	ER/Outpatient		Othor		Residence 6	Other: Scene	
ing Ph After th	- 1	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I	Injury 28c. Inj	ury at Work?	28d. Describe he	ow injury occurred	to	
ttendi death stor: // the fi	읉	Natural 5 Pending 2 X Accident Investigation	Fd 2/10/09	Fd 8:40	6 am 1	Yes 2X No		mental o		
Division pital or Attendir ours after death ceral Director: A	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre	et, factory, office	building, etc.	or Town Sta	ate) 6/1/1 T	or Rural Route Number, Washington B	City 31v
Ospita hours uneral	아	4 Homicide determined			ant lot					- 3
Division of Vital Records, P.O. Box 68" To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medical Examiner: Or	To the best of my knowled the basis of examination a	ge, death occui ind/or investigat	rred at the time, o tion, in my opinio	nate and place, and in, death occurred a	due to the cause t the time, date a	nd place, and du	e to the cause(s)	
To To	ĕŀ	29b. Signature and title of certifier	d manner stated.		29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
		PTO RO	Que in		O.C	.M.E.		February 11	, 2009	
	ł	30. Name and address of person who com								
		Patricia Aronica-Pollak MD.	Assistant Medical		111 Penn S	Street, Baltimore	e, MD 21201			
Sta Registr	ite ar	31. Date filed (Month PEB 1 9 20	9 32. Registrar's Signati	JIE A. A	back					

		For State Registrar	Sta	ate of	Marylan	-	rtmen <i>tificate</i>				lental Hy	giene Reg. No.	2009	0	4898
		Decedent's Name (First, Middle)	tle, Last)	-							2. Date of De				ime of Death
Physicia		Mary A. Blis	S								Month Februa	ry 3	Year 2009	1.	41 AM M
/Medica		4a. Facility Name (If not instituti		and numi	ber)	I	4b. City,	Town, or	Location	of Death	TCDIGG		County of Dea		41 An
Examine	ŧr	Gilchrist Ho	-		,		Tow	son				ī	Baltimo	ra	
Funeral		5. Social Security Number	6. Sex	7	. Age (In yrs. I	ast birthday)	If Under	1 Year		r 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (	State or Foreign
Director		218-26-3688	1 □ M 2	∏F	76	Yrs.	Months	Days	Hours	Min.	Mar 1,	1932 1932		o <i>untry)</i> v1ano	d
		Usual Residence of Decedent											12.00.2		
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a-f s	턍	MD Balt	imore			Tows	on							1 [	□Yes 2√√ No
or 28	jre	10e. Street and Number					10f. Zip	Code				10g. Citiz	en of What C	ountry?	
th will	<u>'a</u>	221 Camberley	Circle	#A4				21	L204				USA		
dea	Funeral Director	11. Marital Status		as Deced	ent Ever in U.S	S. 13. V	Vas Deced	ent of His	spanic O	rigin? (Sp	ecify Yes or No Rican, etc.)	- 1	4. Race - Am- Black, Whit		lian,
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be fi	Be	John A. Ahle									eine Cl		ourname)		
d Me nark	၉			.!-4\		40h Mailin	n A ddun no	/Ctt					Town Ctate	7:- Ondo	
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ges if of l		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		al from Si		emetery, crem	atory or o	ther place	9)	,	Jate	200. L00	Dation - Oity Oi	TOWIT, O	iaic
t Pa tmer tant:		4 Donation 5 ☐ Other	1	1											
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be redified at once.		21. Signature of Ronal d	esicensee S. Ward		irector		ate A 1timo				655 W.	Ba1	timore	Stre	eet
		23a. Part . Enter the disease,										rrest,		Appro	oximate val Between
Physician		shock, or heart failure. Li	st only one cat	ISE OII Ea	or line.	20 0	_	000		_					et and Death
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sician: The la certificate ha irector, page 3	Be	25. Was case referred to medic examiner?	al						26. Plac	ce of Deat	h (Check only o				
hysic nis ce	ည	1 Yes 2 No	Hospit	al: 1 □ In	patient 2 🗌	ER/Outpatien	t 3 🗆 DC	Othe	r: 4 □ N	Nursing Ho	ome 5 ☐ Resi	dence 6	Other (Sp.	ecify) N	OSPUG
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er Att ter d irect n by i	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	mined 28	e. Place o buildin	of Injury - At ho g, etc. <i>(Specif</i> )	me, farm, stre v)	et, factory	, office			28f. Location ( City or To	Street and wn, State)	d Number or F	ural Rout	te Number,
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		al Examiner: (		sis of examina						and due to the red at the time,				ause(s)
To th Vithir Comp	Me	29b. Signature and title of certif	ier				290	. License	number			29d. Date	e signed (Mon	th, Day, \	Year)
		) (Nenas	lin	)			)	)S	83	05		Fesn	wary	32	009
		30. Name and address of person	n who comple	ted cause	of death (Item	n 23a) (Type, I	Print)								,
		AMON T CAH	ALIRS	W	670	1 N. C	we	les	ST	Tow.	1 MOL	1	2920	4	
Stat	e	31. Date filed (Month, Day, Yea		32 Re	gistrar's Signa	ture —			-		-			1	
Registra	ır	FEB1	2009	Der.	was p	9. 190	2 pour								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C889 3/24/09 TH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** February 9, 2009 11:14 AM Edith P. Bailone /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral **213** 32-8658 Months February Days Hours 1 □ M 2 🛱 F 92 Director Dec 13, 1916 New Hampshire Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho The Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Baltimore Parkton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21120 1740 Harris Mill Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. þ white 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 0 unk clerical permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, In Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Charles Potter Edna Denton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Wismer/niece 1740 Harris Mill Road Parkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 23a. Parl 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death **Physician** /Medical Examiner repeness Obelilit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given are I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Vital 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ot 28d. Describe how injury occurred if the ent was witing with water. Lost Balance in 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? AStar KOON PM Division 1 Natural 5 Pending February 4, 2019 investigation 1 ☐ Yes 2 ☑ No Fell in top of the contrel

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1740 itamis mil Rd. Parkton, MO Home 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30, Name and address of person who completed caused death (Item 23a) (Type, Print) W. A. R. Ley CBMC 670 (N. Che 6701 N. Cheles St. Golto and Ziedy 31. Date filed (Month, Day, Registrar's Signatur State Lane Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year CONNIE BURNETTE DEBORAH 8.45 PM 3008 02 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewill CAME BALTIMORE FUTURE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours 215-60-0019 Yrs. Director MARCH 22,1952 MARYLAND Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits ems 23a or 28a-f sho 1 Yes 2 □ No Directo MARYLAND BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 501 E. RESTON ST., APT. 12 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No or Items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene.
Important: If item Z7 is marked other than "natural", or iten any injury or other traumatic event, If a Marical Evanina.
any injury or other traumatic event, If a Marical Evanina. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE HOMEMIAKER DWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CECELIA ROBERT GRIFFIN SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD BURNETTE (403BAND 501 E. PRESTON ST., APT. 727, BALTIMORE, MD 2 1202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State STERN CEMETERY OR/20/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

DSEPH H. BROWN JR. FUNERAL HOME

RIYON. FULTON AVE., BALTIMORE, MD RIS 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Acer dens Physician ress vanda disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence off. certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.0. ☐Yes 2 ALMO 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed certificate has birector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 2 🗆 No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation hours after death. Il Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide vithin 24 hours after To the Funeral Dir Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 31464 MD

DHMH 17 Rev 1/2001

State Registrar SINAIB A

31. Date filed (Month, Day, Year)

HOSEMIND, 821 N. EVTAW ST ENTE 300 BALTIMOIZEMD 2121

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00213 2009 04901 State of Maryland / Department of Health and Mental Hygiene Terell Bannister, Jr. Certificate of Death 1- For State Reg. No. Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 8, 2009 0146 hrs Medical Examiner Terell Bannister Jr 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 1227 Beaumont Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Numberunk 6. Sex **Funeral** Min Months Day: Country) Director 1 X M 2 Dec 10 2008 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County any 10a State 1 X Yes 2 No Baltimore MD s 23a or 28a-f show e notified at once. 28a-f show Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 1227 Beaumont Avenue 21239 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 2 X No Yes Specify If Yes, Give Year Yes 2 X No specify: white Divorced Widowed à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) 21215-0036 infant infant infant infant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) April Eining Terrell Bannister, Sr. (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Charles St. Baltimore, MD 21218

1 Street Baltimore, MD 21201 19a. Informant's Name/Relationship (Type, Print) 2 O.C.M.E.April Eining-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State ount Crematory 2/21/2009 Baltimore.
22 Name and Address of Facility March Each FH 1101 E.
State Anatomy Board 655.Wx.Baltimore Greenmount Crematory otate North Ave. Runeral Service Ucensee Runald Wade 21202 Baltimore, MĎ t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death Medica a Sudden unexpected neonatal death Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and 2/27/09 per FH G888 g890 4/6/09 Physician/Medical 17,19a-b,20a-c,22, 23a,27,28a-f,perME TTUNPENDED physician a the burial - 1 X AMENDED 23d Date of delivery Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth the attending use as 1 past 12 months Pregnant at time of death 5 Other (Specify, Jo. 1 Yes 2 No 9 Unknown g Unknown signed by the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 0.0 Yes 2 No 3 Probably 4 ✔ Unknown è Completed 24b. Were autopsy findings available 24a. Was an Records, After this certificate has been funeral director, page 2 should prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 2 Nο 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other: Hospital: 1 examiner? Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 DOA Inpatient 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Yes 2 X No unk Natural Pending the f Fd 1/8/09 Fd 1:42 ath Director: Accident Investigation 28f. Location (Street and Alember or Rural Route Number, City or Town, State) 1227 Beaumont AVE Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Could not be Suicide found at home determined Homicide

Hospital or Attending Physician: The law requires that the death 24 hours after death. filled in by To the

29a. Certifier (Check only

Signature and title of certifier

Patricia Aronica-Pollak MD.

FER 1 9 2009

31. Date filed (Month; Day, Year)

and manner stated

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 8, 2009

State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 04902 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1.0 Gerald Lee Battle 2009 21:30 M 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death N/A Mercy Medical Center 8. Date of Birth (Month, Day, Year) 9-29-1948 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours Min 1XXX 2 □ F Months 60 212-46-4239 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pratt 1100 E. Street 21202 S A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐Yes 21 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residental Truck Driver 8th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert James Battle Hester Smothers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorine Battle-Wife 1100 E. Pratt Street Balto, MD 21202 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount 2-17-2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Foneral Service Licensee Brand-Mille 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest Minutes disease or condition resulting in death) Due to (or as a consequence of): Congestive Heart Failure Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2☐ER/Outpatient 3☐DOA

burial-transi and anding physician ause as the burial-Box 68760, certificate be nse atter for u that the death signed by the a o. σ. of Vital Records, page 2 s has certificate Physician: this funeral After I or Attending I after death.

after death.

Director: Af

within 24 hours a To the Funeral C Hospital

completely filled in by

Division

**Physician** 

/Medical

Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified at once.

Baltimore, Maryland 21215-0036

Exami Physician/Medical ģ Completed Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

(Check only one) 29b. Signatur

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MO, 178P

29c. License number 29d. Date signed (Month, Day, Year)

30. Name of person who completed cause of death (Item 23a) (Type, Print) Steuhe

78F

32. Registrar's Signature

Registrar

phen 31. Date filed (Month, Day, Year)

1e

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signatur

Pamela E. Southall, MD

31. Date filed (Month, Day, Year,

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 12, 2009

Certificate of Death

4:00 PM 4c. County of Death Baltimore Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 ☐ Yes 2XNo 10g. Citizen of What Country? U.S.A. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Railroad 20c. Location - City or Town, State Approximate Interval Betweer Marths

23d. Date of delivery

1 Yes

29d. Date signed (Month, Day, Year)

2009

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Year

Month

Reg. No. 2 0 0 9

3. Time of Death

within 24 hours a

To the Funeral C

1 - State Registral

441

State Registrar

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Faukrermo

111311 McCormick

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 12,2009 OPROTMY EBRUMRY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PANEC BATTMORE TIMONIUM MAYS if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 1916 Director 215-05-6535 MAryland Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 □Yes 2 ☑ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Treeway Ct., Apt. 1-A 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give N Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: <u>م</u> 3 Widowed 4 □ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Vice-President Savings & Loan permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If item 27 is marked other any Injury or other traumout. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Joecke1 Julia Pietsch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, Maryland 21042 Donald R. Tiedemann 3801 Paul Mill Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4☐Donation Hilltop Service Corp. 2-13-2009 Towson 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KENAL CELL YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signated be 1 Yes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 153045 FEBRUARY 13, 2009

DHMH 17 Rev 1/2001

State Registrar 12221

31. Date filed (Month, Day, Year)

Barker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signature

Tucemore

FEB 19 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 09 BEATTY 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner REHAB + NSG ST. ELIZABETIA CENTER 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Months 1 □ M 2 및 F 88 214-14-4035 Aug 23, 1920 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "natural", or items 23a or 28e-f ehow the Wedical Examinar must be notified at Baltimore MD 1 AYes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 2738 Daisy Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify White 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "na any injury or other treumatic event the potent." Flementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Smith James Merrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherrie Cyr daughter 2738 Daisy Avenue Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park February 20, 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee Mourco 237 E. Patapsco Ave. Baltimore, MD 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician moath /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner page 2 should be detached for use as the burlal-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1 Yes ospital or Attending Physiclen: Thours after death.
unerel Director: After this certificately filled in by the funeral director, pa Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes ② No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Vent 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Tyes 2 □ No Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD en15'077 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 9 2009 Registrar DHMH 17 Rev 1/2001

			For State	State	of Maryl		artment of F		Mental Hy	giene Reg. No. 2	009	04907
			Registrar  1. Decedent's Name (First, Middle)	e, Last)	- i		- timouto or i		2. Date of De	eath		3. Time of Death
	Physicia		Christm	a	Cha	se			Month O Z	O3	O G	8:58 PM
	/Medic Examin		4a. Facility Name (If not institution	n, give street and	number)	lospital	4b. City, Town, or	Location of Death	no		nty of Death	none Citu
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth .	9. Birthp	place (State or Foreign
	Director		103-60-0498	1□ м 2√2	F 43	Yrs.	Months Days	Hours Min.	(Month, D.) Mar 3,		New	v York
	p ,		Usual Residence of Decedent  10a. State 10b. County		100	. City, Town or Le	antion				11	0d. Inside City Limits
	aryla shov	'n	MD 10a. State 10b. County		100	Baltim						1√2 Yes 2 □ No
	the M	recti	10e. Street and Number	-		BUILTIN	10f. Zip Code			10g. Citizen o	of What Cour	
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	ms 2;	Funeral Director	11, Marital Status	12. Was [	ecedent Ever i	n U.S. 13.	Was Decedent of H		pecify Yes or No	o- 14. R	lace - Americ	
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2	filed other ent,	Be C	17. Father's Name (First, Middle,	Last)		1		18. Mother's Nam	ne (First, Middle			unk
land	uld be Menta rked ritic ev	To E	Emmett Tobias	Carter								
Магу	and hard		19a. Informant's Name/Relations	ship (Type. Print)		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Tow	ın, State, Zip	Code)
<u>.</u>	and and and mall man man man man man man man man man man		Leonard Peter	son/frie			8 Moravia		altimor		21206	
More	Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Heath and Mental Hygiene. Int: If tiem 27 is marked other than "natural" or items 23a or 28a-f show int: If tiem 27 is marked other than "natural" or items 23a or 28a-f show int or other traumatic event, the Medical Evaning contract to coffice at		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☑ Other (\$		1	b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location	n - City or To	wn, State
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			23a. Par 1. Enter the disease, of	complications th	at caused the o		altimore,			arrest.		Approximate
		a 1.	shook, or heart failure. List Immediate Cause (Final	only one cause	on each line.	1	244		C	- 10 0	Q.	Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	aV	to (or as a con	sequence of:	om sy	ISTERN T	railo	me		
	Examiner				500	Fi C	shock	-				1 month
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o X	certif nding Ise as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes	outcome of pro	egnancy				23d f	Date of delive	Prv
C. BOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	4 □ F	ive birth 2 🗀 regnant at time Inknown		☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		I	Month	Day Year
7.	hat the		Part II. Other significant conditi	ons contributing	to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to the	ne cause of death?
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0	endin eath. or: Af he fur	atio	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	gation	wonan, bay, roa	injury		Yes 2 □No				
DIVISION	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	28e. P	lace of Injury - / uilding, etc. (S	At home, farm, st becify)	reet, factory, office		28f. Location ( City or To	Street and Nur wn, State)	nber or Rura	al Route Number,
_	potral ours a neral I		29a. Certifier 1 Certifyii	na Physician: To	the best of my	knowledge, dea	th occurred at the ti	me, date and place	and due to the	cause(s) and	manner as s	stated.
	he Hos n 24 h he Fun pletely	Medical		Examiner: On the			nvestigation, in my o					
	Voithi Com	Ž	29b. Signature and title of certifie	r //	2/	111	29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
			> X	el fo	me	100	P	21+1	5	02	103	109
			30. Name and address of person	who completed	cause of death	(Item 23a) (Type,	Print) Rain	200 Q1.10	1. Bal	+mann	o MAN	21239
	Sta	ite	31. Date filed (Month. Day. Year)	1 rurk	Registrar's S		en el de la como	an Diva	17 000	TIMOTE	1110	2100/
	Sta Registr		31. Date filed (Month, Day, Year)	2009	grown.	p. 490						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#20a-SperFH. G888.2/19/09 WS State of Maryland / Bepartment of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 20ď9 Joseph Colbert, Jr. 1835 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltoimore County Gilchrist Hospice 7. Age (In yrs. last birthday)
57 vr If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10/16/51 5. Social Security Number Months Days Hours Min. MIM 2DF 218-58-3193 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location N/A Baltimore 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21217 USA 710 N. Payson St. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. African 11 Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give 1970-71 Year or Dates. 1 ☐Yes 2 No Specify: <sup>S</sup>Afferican 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Social Service Admin. 17. Father's Name (First, Middle, Last)
Joseph L. Colbert, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Henriette Colbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph L. Colbert, III/Son 710 N. Payson St., Balt., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place Garrison Forest Bayview Crematory 20c. Location - City or Town, State 20a. Method of Disposition +₩ Burial 2X Cremation 3 ☐ Removal from State Owinds Mills, MD Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitari P. Close F. Svs, PA 21. Signature of Furreral Service Licenses 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Oval CANCEV Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 robably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NS PCH 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, attending physician the certificate has been this funeral After

is been signed by the should be detached s after death. filled in by the within 24 hours a

**Physician** 

/Medical

10a. State

MD

Director

Funeral

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Completed

Be

Examine

Physician/Medical

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Be

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at

Hygiene.

marked other

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event,

Physician

/Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

Registrar

29b. Signature and title of certifier

6 Could not be

determined

29c. License number

† Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFRON J CHARUES 6701 N warrien ist

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 9 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

09-01240 John Clark

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Dear	th	Reg.	No.	
Physicia	n/	1. Decedent's Name (First, Middle,Last)		Date of Death     Month D	av Year	3. Time of Death
Medical Examin		John Clark	6	Month D February 11		1037 hrs
			Town, or Location of Death		4c. County of Death Anne Arundel	
			der 1 Year   If Under 24Hrs.	Pote of Birth/	MM/DD/YYYY) 9. Bir	
Funeral Director		Mont			Foreig	on l
Director		212-06-8745   1 x M 2 F   39 Yrs.		Aug. 24	, 1969 Co	ountry) Maryland
) m	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			*	10d. Inside City Limits
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Mar rr 28s	Director			Tog.	Citizen of What Cou	110 y 7
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death with the Maryland or items 23a or 28a-f sho	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spec	dent of Hispanic Origin? ( Sp cify Cuban, Mexican, Puerto		White, etc.	ican Indian, Black,
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irs aff	<u>ē</u>	or Dates:	al Occupation (Give kind of w	ork done	6b. Kind of Business/	hite Industry
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36 thin 7 than edica	힐	12 Handyman		•	Maintenan	ce
5-0C led will tygier other	등	17. Father's Name (First, Middle, Last)	18.Mother's Name			<u> </u>
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiper must be notified at once	Be	Rodney P. Clark, Sr.	Darlene	Metzler		
21 hould I hould I he mar is mar utic ev	2		ss (Street and Number or R	ural Route Numbe	er, City or Town, State	e, Zip Code)
Baltimore, MD 21215-0036 permit; Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than injury or other traumatic event, the Medica		Rodney P. Clark, Jr. / brother 772 Ancho	or Chain Rd.	#4, Oce	an City,	
ore, No.		20a. Method of Disposition 20b. Place of Disposition (Na	ame of cemetery,	Date 2	20c. Location - City or	Town, State
Baltimore, Nemit. Pages 1 and Department of Health Important: If item injury or other tran		1 Burial 2 X Cremation 3 Removal from State crematory or other place 4 Donation 5 Other Specify:  Metro Cremator	Feb.		Catonevill	e, Maryland
Baltimo permit: Pag Department Important: injury or o		21. Signature of Fymeral Sociole Licensee 22. Name and	nd Address of Facility ey-Ruddick Fu	2009 1	Catonsviii	e, Maryranu
		SA Fundame (421 C)	ey-Ruddick Fu rain Hwy. SE;	neral Ho Glen B	me, P.A. urnie. MD	21061
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode	of dying, such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical	-	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic cardiov	ascular disea	se		Death Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):	E 4 993			1
		Sequentially list conditions, b.				
	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				1
	E	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
xecuted , secuted transit	٩l	d.				
• ਫ਼ਾਜ਼ ।	/Medical	X UNPENDED 23a,PII,27,perME,	g889 3/20/09	TT		
760, Tcate be 3 physici the buri	š	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	у
687 ertific ding ;	_	23b. Was decedent pregnant in the past 12 months?	h 3 Ectopic pregna	ncy	Month	Day Year
that the death certife ned by the attending detached for use as	Physiciar	4 Pregnant at time of death 5 Other (Sp	pecify)			
the de the dy the	튑	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e, Did toba	acco use contribute to	the cause of death?
P.C res that signed b	2	Diabetes mellitus	.g g	1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
ords, F w requires s been sign	ted			24a. Was an	ı 24b. Were a	utopsy findings available
corc	흷	<u> </u>		autopsy perform	prior to	completion of cause of
Rec The I	Completed		_	1 🗸 Yes 2		es 2 No
Vital Rec	8	25. Was case referred to medical examiner?	26.Place of Death (Check of			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	ᇍ	1 Yes 2 No Inspiral 1 Inpatient 2 ER/Outpatient 3			esidence 6 🗸 Othe	er: Scene
1 of ding Ph	إڃ	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	28c. Injury at Work?	28d. Describe how	w injury occurred	
trend teath.	<u>≝</u>	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Divis pital or At ours after d ceral Direct filled in by	<u></u> €	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	ry, office building, etc.	28f. Location (Street or Town, State		ural Route Number, City
D Hospital 24 hours Funeral tely filled	Certification:	4 Homicide determined (Specify)				
n 24 h		29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of my knowledge, death occurred at the control of the best of the best of my knowledge, death occurred at the control of the best of the b				
Division of Vital Records, P.O. Box 68 within 24 hours after death.  To the Inspiral or Attending Physician: The law requires that the death certif To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in n and manner stated.				
	Σ	29b. Signature and title of certifier	9c. License number		29d. Date signed (Mo	
		D_ W IL, M	O.C.M.E.		February 12, 20	09
d	ľ	30. Name and address of person who completed cause of death (Item 23a)				
Y			Street, Baltimore, M	D 21201		
Sta	~	31. Date filed (Month, Day, Year)  32. Registrar's Signature				
Registr	ar	FEB 1 9 2009 Cenar S. Sarles				

			For State Registrar		State of	of Mary	land / Dep	artment ertificate						UU:	3	049	
			Decedent's Name (First, A.)	liddje, La	ist)			rimoate	01 1	Jean		2. Date of De				3. Time of	Death
	Physici		HENRY.	(10	GDF/	1						Month 62	Day		ear	16	00 M
	/Medio Examin		4a. Facility Name (If not insti	ution, giv	re street and nu	umber)		4b. City, To	own, or	Location	of Death		-	County of			
		-	FUTURECARE	ном	EWOOD					RAT	TIMO	)RE					
ī	Funeral		5. Social Security Number	6. 5	Sex	7. Age (In	yrs. last birthda		Year Days	If Under Hours		8. Date of Bir	th Vear	5	). Birthpi	lace (State or	r Foreign
	Director		218-26-7978		<b>X</b> M 2□ F	78	Yrs.		Juyo			08-28	-193	0		""NC	
	and w		Usual Residence of Deceder 10a. State 10b. Co			10	c. City, Town or	ocation							11	0d. Inside Cit	v Limite #
	Aaryf.	ច		LTIM	ORE		-	NER STA	TIO	N					( )	X Yes	•
	28a-	rect	10e. Street and Number					10f. Zip C	ode				10a Citi	izen of Wh	at Coup		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, I've Modical Examinational be notified at once.	Funeral Director	736 PEACH OR	CHAR	D LANE			10.11 2.15		21222	2		. og. o		ISA		
	death ms 2	Jera	11. Marital Status	<del></del>	12. Was Dec	cedent Ever	in U.S. 13	. Was Decede	nt of Hi	spanic Ori	igin? (Spe	ecify Yes or No	)-	14. Race -	America		
ဖ	after or ite	2	1 Never Married 2	Married		2 <b>X</b> No		If Yes, specify				Rican, etc.)			White, e		
21215-0036	rai',	d by	3 ☐ Widowed 4 ☐ Divo	rced	If Yes, G Year or t			1 ☐ Yes 2	ANO	Specify:				Specify:	BL.	ACK	
ς.	72 h 'natu	Completed		edent's E	ducation ade completed	)	16a. Dec	edent's Usual e kind of work DO NOT use	Оссира done d	ation furing mos	t of worki	ing	16b. Ki	ind of Busin	ness/Ind	lustry	
2	vithin ne. <b>hen</b>	mpi	Elementary/Secondary (0-	12)	College	(1-4or 5+)							_				
	iled v tygie her t		10 17. Father's Name (First, Mid	Idlo I aci	1		CRA	IN OPER	ATO		ada Niassa	- (Files Adida)		ETH S			
Maryland	otal Pefort	Be	JOHN HENRY C							18. Motne		ODIA MO		,			
ž	houid d Me nark natic	잍	19a. Informant's Name/Rela				10h 14-	tion Address (	2			-					
Ma	d 2 s th an 7 is r treur											al Route Numb					
	1 an Healt em 2		CORINE COGDE  20a. Method of Disposition	LL/W	IFE	2	Ob. Place of Dis			ORCH/		ANE, B		MD cation - Ci			
<b>Baltimore</b> ,	ages nt of t: H it		1 X Burial 2 ☐ Crema				cemetery, cr	ematory or oth	er place						•		
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Ba	Depa Impo any ir		Jam		9.7	Lot	in					, BALT				э г.п.	, INC
			23a. Part 1. Enter the diseas shock, or heart failure.	e, or com	plications that	caused the each line.	death. Do not e	nter the mode	of dying	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Betw	een.
8	Physician		Immediate Cause (Final disease or condition			Sta	oKo									Onset and D	
	/Medical		resulting in death)		Due to	(or as a co	nsequence of):										
	Examiner		Sequentially list conditions,	- 1	b												
\\ \'\'	모 등	iner	if any, leading to immediate cause. Enter Underlying		Due to	(or as a co	nsequence of):										
30	ecute and -trans	Examine	that initiated events resulting in death) Last		c	(											
,8760,	icate be executed physician and s the burial-transit	Ē			Due to	(or as a co	insequence of):										
87	cate t	dlcai			d	<u> </u>			-						-		
Θ	ding I	/Me	IF FEMALE:		23a Huge o	stoome of a	10GB2BG1										
Box	eath certifi attending I for use as	lan	23b. Was decedent pregnar in the past 12 months?	t		birth 2 🗌	Fetal death 3	□Ectopic preg					11 2	23d. Date of Month			ear
P.O.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unkr	nant at time nown	or death 5	Other (spec	:rry)							1	
	The law requires that the death certifi tie has been signed by the attending bage 2 should be detached for use as	by Physician/Me	Part II. 9ther significant co	ditions	contributing to	death but no	at resulting in the	underlying cau	se give	n in Part I		23e. Did t	obacco u	use contribu	ute to th	e cause of de	eath?
ds,	uires sign d be		Viabeles.	ATT	rul Fr	lonth	ul	,,	J			1 🗆 '				ably 4 ⊟Ui	
Record	w requir been si should	Completed				•											
Re	Physicien: The lav this certificate has al director, page 2	mp										24a. Was	an psy ormed?	prio	re autop or to com ath?	sy findings a apletion of ca	valiable use of
a			05 Mes	-411	T							1 Tes	2 12 No		Yes	2□ No	
Vital	Physicien: rthis certifica ral director, I	) Be	25. Was case referred to me examiner?	<del>a</del> rcal	Hospital:				Othe			(Check only o					-
of	Phy r this araf d	.: To	1 Yes 2 Valo		28a. Date		2 ER/Outpati		1	4 11111		me 5 Resi				)	
Division of	ding th. : Afte	ţ	1 Vatural 5 Pe	ending restigation	(Moi	nth, Day Ye	ar) Injury	м	Injury Work	:?ົ` ∕es 2.⊟I			now anjur	, 00001100			
/ISI	or Attending tter death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ C	ould not b	28e. Plac	e of Injury -	At home, farm, s	treet, factory, o			-	28f. Location (	Street an	d Number	or Rural	Route Numb	er.
ă	after after Direct	Certification;	4  Homicide		build	ding, etc. (S	(pecify)	, , , ,				City or To					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Cer	ifying Pl	hysician: To th	e best of m	y knowledge, de	th occurred at	the tim	e, date an	d place, a	and due to the	cause(s)	and mann	er as sta	ated.	
	n 24 he Fu he Fu	edical	(Check only 2 Med one)	ical Exa	miner: On the t	basis of exa nner stated.	unination and/or	nvestigation, ir	my op	inion, dea	th occurre	ed at the time,	date and	place, and	due to	the cause(s)	
	To the Hospitei o within 24 hours aff To the Funerel Di completely filled in	Σ	29b. Signature and title of	rtifler		/	/	29c. I	icense	number			29d. Dat	te signed (/	Month, E	Day, Year)	
•						to	1) 00	)	Ho	06+1	138		2	117/	200	9	
	5		30. Name and address of	rson who	completed cau	ise of death	(Item 23a) (Type	, Print)	,	Roya	/	1	7 1.	(	,	9 2121	
_			Joset	441	Kul	0.0	16ch	W.	47.	Keye	1/1	we. L	Salt	no,	40	2161	7
	Sta		FEB 1 9 200		32. 1	Registrar's	-			l		,		(		7	
	Registr	ar	LCB T 2 500	5 /	Lucia	S.	barres										

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Norman Disidoro 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Homics PENINSULA REGIONAL MEDICAL 34436424 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day June 27 9. Birthplace (State or Foreign Country) unk 5. Social Security Number 7. Age (In yrs. last birthday, . 1936 Days Hours Months 1 ☑ M 2 □ F 72 143-40-0079 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Wicomico 1 ☐ Yes 2 ☑ No Salisbury 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 421 Jefferson Street 21804 USA . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No un If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penninsula REgional Hospital 100 E. Carroll Street Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5፟፟MOther (Specify) in state 21. Signalure Jameral Service Licens Tane, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOVASOULAR ATHEROSCIERITI Due to (or as a consequence of): Egypantially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a, Was an autonsy perform 2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital:

**Examiner** Hospital or Attending Physicia The law requires that the death certificate be executed burial-trai Division of Vital Records, P.O. Box 68760, attending physician for use as the buria been signed by the certificate has irector, page 2 sl this c After this funeral of within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical

<u>≨</u>

Completed

Be

Medical Certification: To

**Physician** 

/Medical

**Physician** /Medical

Examiner

Director

Funeral

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it will confire training any injury or other traumatic event, it will confire than any injury or other traumatic event, it is will confire than any expressions.

Baltimore, Maryland 21215-0036

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

ASTERN SHIRE DR.

29d. Date signed (Month, Day, Year)

and manner stated.

31. Date filed (Month, Day, Year) 9 2009 37. Registrar's Signature

State

Registrar

09-01314 Michael Kevin Davis, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 04913

		I- For State Registrar		Cert	tificate o	f Death			Re	g. No.			
Physicia edical Exami	ın/	Registrar  1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year February 14, 2009  3. Time of Death 0152 hrs										th	
		4a. Facility Name (if not instituted 4510 Erdman Avenue	on, give street and num			4b. City, Town Baltimore		of Death		4c. Cou	inty of Death	1	
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. Ia	st birthday)	If Under 1 Months I	Year If Under		. Date of Birt		Foreig	thplace (State or	
Director		213-96-9856	1 X M 2 F	30	) Yrs		Juys Hours	J IVIII I.	9-18	-1978		ountry) MD	
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Local	tion	-					10d. Inside City	
land f show	اق		/A	Balt	timore		-			0.00	4 M/L -4 0	1 <b>X</b> X Yes 2	No
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygier than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1633 N. Was	shington	Street	t	10f. Zip Coo 2	1213		10	US			
ath with tems 23	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Dece	dent Ever in U.s		as Decedent of es, specify Cu					Race - Amer White, etc.	ican Indian, Blac	ck,
nfter de ul", or i			vorced If Yes, Give Year	2XX No	1	Yes 2xx	No specify			Spe	cify:	Black	
hours a natura Exami	ompleted by	15. Decedent's Education (Spe				nt's Usual Occi nost of working				16b. Kind	of Business/	Industry Un	k
336 thin 72 ne. than "	nplet	Elementary/Secondary (0-12)		/A	Lab	orer							
5-06 ed wi tygier other	Š	9th grade 17. Father's Name (First, Middle	e, Last)	/ 23			18.Mothe	r's Name (Fi	rst, Middle, N	Maiden Surr	iame)		
21215-0036 and be filed within 7 Mental Hygiene. marked other than ic event, the Medica	å	Michael Kev		Sr				orgia					
D 21 should and Me 7 is ma	욘	19a. Informant's Name/Relation Georgianna		or	100	ig Address (S R NT W7				•		e, Zip Code) MD 21	212
e, M 1 and 2 Health item 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name o	f cemetery,	D	ate	20c. Loca	tion - City o	TOWN, State	<u> </u>
MOF Pages   tent of   mt: If		1 X Burial 2 Cremation 4 Donation 5 Other S	n 3 Removal from	m State K	-	ther place) emoria		2-20		1		stown,	MD
Baltimore, MD 21 pernit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		21. Signature of Funeral Service		,	22.	Name and Add						MD 212	0.2
Physician	rti U	23a. Part I. Enter the disease, o	r complications that car	used the death.	. Do not enter							Approximate	Interval
Medical	7 13	failure. List only one cause Immediate Cause (Final disease	e on each line.									Between On Death	
xaminer		or condition resulting in death)	Due to (or as a c										
	ner	Sequentially list conditions, if any, leading to immediate	bb. Due to (or as a c	consequence of	f):								
d it	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of	f):								
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8760, ifficate be exend physician as the burial	Medi	IF FEMALE:	23c. If yes, o	utcome of preg	nancy						ate of delive	-	
Sox 687 leath certific e attending p for use as th	ian/	23b. Was decedent pregnant in past 12 months?	I _ Live bit	rth ant at time of de	oth _	etal death other (Specify)		ic pregnancy	у	Moi	nth	Day Y	еаг
Box 68 e death certi the attendin ed for use a	Physician/Medical		nknown g Unknow	wn	J								
b, P.O. I	by	Part II. Other significant cond	itions contributing to	death but not re	esulting in the	underlying cau	use given in F	Part I.				the cause of de	
rds, require been sig	Completed								24a. Was			utopsy findings a	
of Vital Records, g Physician: The law requir After this certificate has been s neral director, page 2 should b	dwa				_					rmed?	death?		No
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Vita hysici: this co	To B	examiner? 1 ✓ Yes 2 No		patient 2	ER/Outpatier		Other <sub>4</sub>	Nursing H			6 🗸 Oth	er: Scene	
_ = _ < 2			28a. Date of (Month, anding Feb 14, 2	of Injury Day Year) 2009	28b. Time of 0143 hrs		Injury at Wor Yes 2 ▶	_ ISI	d. Describe ubject sho		occurred		
Division tal or Attendir rs after death.  al Director: Aled in by the fu	Certification:	3 Suicide 6 Co	uld not be	of Injury - At h	ome, farm, str	eet, factory, off	ice building, e		or Town	State)		Rural Route Numb	ber, City
Divospital of hours at meral D		4 V Homicide det		Parking Lo					10 Erdman	Avenue,			
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	/Chank anti-	Physician: To the best aminer: On the basis or and manner sta	f examination a	ge, death occi and/or investig	urred at the tim ation, in my op	e, date and p inion, death o	orace, and du occurred at th	ne to the caus	se(s) and m and place,	anner as sta and due to t	the cause(s)	
7. × 7. 00	Me	29b. Signature and title of certif	ier		-		cense numbe	er Pr				onth, Day, Year)	
			, msp			С	.C.M.E.			⊢ebr∪a	ary 14, 20		
2 1/		30. Name and address of personal Ling Li, MD Assist	n who completed caus ant Medical Exam			et, Baltimo	re, MD 21	201					
	tate	31. Date filed (Month, Day, Year	) 32. Re	gistrar's Signati		and and		-					
Regis	trar	FEB 1	2009 /	escored j	13. Ag a	A. Commercial Commerci				_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician JAMES** 0. DARBY 2009 FEBRUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 X M 2 □ F Yrs. MARCH 30, 1932 DC Director 578-42-5900 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, Ire Medical Experiment and until a rotified at uny or other traumatic event, Ire Medical Experiment and until a rotified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1XYes 2□No **Funeral Director** PRINCE GEORGE'S UPPER MARLBORO 10g, Citizen of What Country? 10e. Street and Number USA 9401 CONCORD DRIVE 20772 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify 2 BLACK Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRINTER PRIVATE 11TH18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM DARBY CHARLOTTIE DARBY ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9401 CONCORD DRIVE UPPER MARLBORO, MD BERNIDA WILLIAMS / DAUGHTER permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN MEMORIAL CEM. 02-20-2009 | SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD SUITLAND, MD 4308 SUITLAND ROAD DONALD R. GRAY 23a. Part 1 Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of lone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** muocard /Medical Due to (or as a sequence of): Examiner comman Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No e Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Pnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

Sumatts Rd Clinton-MD 20 735

30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FFB 1 9 2009

elmo

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:35 AM M February 5, 2009 Mary L. Elliott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's California 45395 Woodlawn Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) Months Hours 1 M 2 7 F 84 Dec 27, 1924 219-12-3752 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Medical Experiment to coulfied any play of the traumatic event, Item Medical Experiment to coulfied and once. 1 ☐ Yes 2√☐ No Director California St. Mary's MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20619 USA 45395 Woodlawn Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 2 Specify: white 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everett Leathering Mary Estelle Oberny ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jay Elliott/son 45395 Woodlawn Drive Calfornia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signatu e di Funeral Servi e Licensee Rona la S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician physicma Due to (ras a con equence of): /Medical Examiner mentan Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed As hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, specificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the burial-transit she Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No ③ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Chase Dr

29d. Date signed (Month, Day, Year)

		for State Registrar	State of Maryla		artment of I rtificate of		l Mental Hy	200	19 149	16
		Decedent's Name (First, Middle, La	st)		Timoato or	Douin	2. Date of De		3. Time of D	Death
Physic /Med		Dorothy Mary	Eckenrode				Feb.	17, 200	Year 9 12:17	7 P <sup>M</sup>
Exami		4a. Facility Name (If not institution, give	re street and number)			or Location of De	ath	4c. County of	f Death	•
•		Charlestown Ca		t t-l-t-tt	Cator	nsville			timore	
Funeral Director		5. Social Security Number 215–22–7763	TOO	rs. last birthday) Yrs.	Months Days	Hours Mi	n. (Month, Da	th (ay, Year) 1109	9. Birthplace (State or Country) Marylan	Foreign d
D >		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	antine.					
f sho	٥	MD Balti		Catons					10d. Inside City	
the N	rect	10e. Street and Number	MOI C	Catons	10f. Zip Code			10g. Citizen of Wh		
h with	a D	709 Maiden Choi	ce Ln. RGN	221	2	1228		_	S.A.	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Merical Exp. vin et must be routlised at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin?	(Specify Yes or No	14. Race	- American Indian, White, etc.	
or it	by Fu	1 Never Married 2 Married	1 □Yes XXNo If Yes, Give		1 □Yes XX No		orto Friodri, oto.)	Specify:		
hour tural		XXWidowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occup	nation		16b. Kind of Busi	White	
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Vical d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship						er, City or Town, S	, ,	
1 and 1 and Health tem 27		Philip Asplen  20a. Method of Disposition			copperv position (Name of matory or other pla		y, Falls	ston, MI	21047 itv or Town, State	
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로 수본원들 .		21. Signature of Furieral Service Licer						Funera?	11e, MD Chapel P.	7
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/Medical Examiner	١.	resulting in death)	Due to (or as a cons	equence of):						
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uted d insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence on).						
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eath certifi attending for use as	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnanc	су		23d. Date Mont		ar
Physician: The law requires that the death certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	or death 5L	Other (specify) _				bu,	
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siclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		1165 22110	
Physic This c	2	1 Yes 2 No		☐ ER/Outpatie		Nursing	Home 5 ☐ Resi	dence 6 ☐ Other	(Specify)	
_ <b>5</b>	ion	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year,	28b. Time o Injury	Wor		28d. Describe	how injury occurred	I	
Attending r death. ector: After by the funer	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e 290 Place of Injury - At	thome farm str		Yes 2 □ No	28f Location /	Street and Number	or Rural Route Numbe	
alor As after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	oot, factory, office		City or To	wn, State)	or narar noute Numbe	<i>31</i> ,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur		(Check only 2 Medical Exal	nysician: To the best of my l	nowledge, deat	h occurred at the ti	me, date and pla	ce, and due to the	cause(s) and man	ner as stated.	
thin 2 the l	Medical	one) 29b. Signature and title of certifier	and manner stated.							
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H		30. Name and address of person who	= 1	tem 28a) (Type	Print)	, , , ,		1 21 7	1, 00	
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St Regist	ate	31. Date filed (Month, Day, Year).	- 32. Registrar's Sig	nature	Red			*	<b>∀</b>	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Betty Frith 2009 7:00 AM February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 3443 Dunran Road Dundulk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last hirthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 82 212-22-0984 Feb 28, 1926 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be experimed. 10a, State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3443 Dunran Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XIO 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Brown Paul Morris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Weaver, Daughter 3454 Dunran Road Dundalk, Marvland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 02/20/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Puneral Service License Thomas Gregor Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burlel-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Vear Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

31. Date filed (Month, Day,

DEIVE SUITE 101 TOWSON MD 21204

(Item 23a) (Type, Print)

cause of death

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ADELF 1130 M **Physician** NNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Hospice Harwood If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1 M 2 Director 06/08/1929 Virginia 214-46-2223 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it of Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No SC Director Aiken Monetta 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3205 Wire Road 29105 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. yes 1 and 2 should be filled within 72 hours after 0. of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Horse Trainer Equestrian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Fadeley/Daughter 3205 Wire Road, Monetta, SC 29105 Pages 1 and 2 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State = ਨ Important: If any injury or once. 02/19/2009 Anatomy Gifts Registry Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee. 7522 Connelley Drive, Ste.P. Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jauses (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760, physician use as IF FEMALE 23c. if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Doner (Specify) examiner? 1 Yes 2 No PILE Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) House 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of fortifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Type, Print)
DEFENSE HEHWAY HONAPOLIS MORIYUI KENTA W 441 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 09-01390 James Flanary Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nes Flanary		State of Maryland / Department of For State Certificate of	Health and Mental Hy Death	rgiene Reg. <u>N</u> e	
Physician		pgistrar Decedent's Name (First, Middle,Last)		Date of Death     Month Day	Year 2310 hrs
dical Examine	er	James Flanary	, (S - i)	Month Day February 16, 2	2009 23101115 Ic. County of Death
	4	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore		
		University Hospital  Social Security Number 16, Sex 7, Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth(MI	Baltimore City WDD/YYYY) 9. Birthplace (State or
Funeral	5	, Social Security Number	Months Days Hours Min.		Foreign
Director	L	220-17-4630 1 X M 2 F 23 Yrs		Oct. 13,	
ģ		Sual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Local	ion		10d. Inside City Limits
Maryland 28a-f show any d at once.		Maryland Anne Arundel Millersvil	le		1 Yes 2 X No
nrylan 8a-f sl	황는	Maryland Anne Arundel   Millersvil	10f. Zip Code	10g. C	itizen of What Country?
he Ma 1 or 29 iffed	Director	8390 Elvaton Rd.	21108		ited States
death with the Maryland or items 23a or 28a-f sho must be notified at once.	<u> </u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
r death	Funeral	1 X Never Married 2 Married 1 Yes 2 X No	Yes 2 X No specify:		Specify: White
		3 Widowed 4 Divorced If Yes, Give Year or Dates:	nt's Usual Occupation (Give kind of	work done 16t	b. Kind of Business/Industry
hours natur	핆	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	nost of working life. DO NOT use reti	ired)	
36 vin 72 s. than '	ble	N.	'A		N/A
21215-0036 build be filled within 72 hours after death with the Maryland   Mental Hygiene. in marked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at once.	Completed by	1.0 17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maid	en Surname)
215 be file nral H rked o	8	John Paul Flanary, Sr.	Glenda ng Address (Street and Number or	Minton  Bural Bouta Number	City or Town State Zin Code)
Z 5 6 6 2	P	138. Information to the state of the state o		llersville	
and 2 shou tealth and N tem 27 is n traumatic			osition (Name of cemetery,	Date 20	Oc. Location - City or Town, State
nore, MC ages I and 2 s nt of Health a t: If item 27		1 Burial 2 X Cremation 3 Removal from State crematory or c	other place) Feb	20	
Page ment tant:		4 Donation 5 Other Specify: Metro C	rematory  Name and Address of Facility	2009 IC	atonsville, Maryland
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum:	ŀ	11.	Name and Address of Facility Irkley-Ruddick Fu 21 Crain Hwy. SE:	Glen Bu	rnie MD 21061
Physician	-	23a, Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart Approximate Interval Between Onset and
Wedical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Sharp force injuries			Death
aminer		or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of):			
	nine	cause. Enter Underlying Cause			
" = "d/"	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
be executed ician and urial - transit	dical E	d.  LINPENDED AMENDED			
<b>₹</b> \$ 19 3 1	edic	Off Life Life			23d. Date of delivery
O. Box 68760 that the death certificate to red by the attending phys detached for use as the br	Physician/Me	23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3 Ectopic preg	nancy	Month Day Year
x 6 th cert ttendii r use a	icia	4 Pregnant at time of death 5	Other (Specify)		
Bo he dea the dea	hys	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ires that the signed by I be detacled		Fart II. Other significant conditions		1 Yes	2 No 3 Probably 4 V Unknown
ords, I	Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
SOFC law re has be	nple			perform	ed? death?
Rec The ficate ; page	ပ္ပြဲ	25. Was case referred to medical	26.Place of Death (Chec		
Vital Rec nysician: The this certificate I director, page	Be	examiner? Hospital: Inpatient 2 V ER/Outpati	ent 3 DOA Other Nur	Siring Frontier 4	esidence 6 Other:
Division of Vital Records, rater dear require rater death.  The law require rater death.  The The law require rate recent. After this certificate has been simplified in by the funeral director, page 2 should b	음.	1 Yes 2 No  27. Manner of Death  28a. Date of Injury  (Month Day Year)  28b. Time		28d. Describe ho Subject stabb	w injury occurred bed and cut
On C ending ath. or: Al	톊	1 Natural 5 Pending Feb 16, 2009 2216 hrs			
/iSic or Atto ter de birecte in by t	lica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc.	or Town Sta	reet and Number or Rural Route Number, City tte) Street, Baltimore, MD
Div pital o	Certification:	determined (Specify) Local Street			
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	) ja	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation of the basis of examination of the basis of the basis of examination of the basis of the basis of the basis of the basis of the basis of the basis of examination of the basis of the	ccurred at the time, date and place, a igation, in my opinion, death occurre	and due to the cause ed at the time, date a	nd place, and due to the cause(s)
To the within compl	edical	one) 2 Medical Examiner: On the basis of examination investigation and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier	O.C.M.E.	OGME	February 17, 2009
		Theodor Me hay TM www	/		
7		30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examine	111 Penn Street, Baltim	ore, MD 21201	
	State	11100001	parkel		
Regi		EED 1 9 2009 Comment 18. 1	GO GOLD STEEL		

State of Maryland / Department of Health and Mental Hygienen 04920 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 13, 10:30 A M Constance Helen Guttenberger 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartlands Of Severna Park Severna Park Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 21X F Hours Min. 76 Yrs Director 219 28 7500 August 30, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "natural", or items 23a or 28a-1 shov the Medical Examiner must be notified at Maryland Anne Arundel Severna Park 1 ☐ Yes 2√ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 큡 715 Benfield Rd. 21146 USA death Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ð 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 27 is marked of traumatic ever Joseph Mroz Eva Gulozpnska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Cheryl Crowther (Daughter) 220 Robson Rd. Dillsburg, Pennsylvania 17019 If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Sacred Heart Of Jesus 2/17/2009 \*4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Linenses 22. Name and Address of Facility Bruzdzinski Funeral Home\_P.A 1407 Old Eastern Avenue Essex, open Maryland 21221 23a Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as i attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) signed by the aid be detached for Ó 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Arrhythmia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 1□ Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Tiving Facility 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 🖾 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospitel or Atte within 24 hours after der To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) enriterRiedinger Veterans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17<sup>Pay</sup> **Physician** Month 2009 Rosalyn Bernadette Guzman 10:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Care TOWSON Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/15/1977 Birthplace (State or Foreign Country)
 CO **Funeral** Months Days Hours Min 220-94-8445 31 **Director** Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Examiner must be notified at MD Baltimore Baltimore Director 1 Tyes 2 NO 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 15 LaVern Ave 21227 Funeral Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 5 1 □ Yes 2 □ No <u>^</u> Specify Specify: White 3 Widowed 4 Divorced "natural", Completed er than "natura 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home maker home maker 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larry Steven Jordan I Sharon L. Evans ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 is or other tra Michael Daniel Guzman/spouse 15 LaVern Ave Baltimore MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. 1 ☐ Burial . 2 【I Cremation 3 ☐ Removal from State Metro Crematory 2/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Catonsville MD 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Ten I Service 21. Signature M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NLVAR Physician /Medical Due to (or as a consequence of): Examiner IMMUNOSUP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed MARRIN and burial-tran Due to (or as a consequence of) Box 68760. signed by the attending physician dbe detached for use as the burial FRANCONI'S Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Rosalyn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, \$ 2 No 1 Tes 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has autopsy perform 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS 1 (4 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA ot completely filled in by the funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury death. within 24 hours after death To the Funeral Director: 1 ☐Yes 2 ☐ No 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VES MM) (0701 32. Registrar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04922 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** FEBRUARY 10, 1948 GAINYARD 2009 NADINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🛛 F Director 579-62-0501 62 AUGUST 19, 1946 SCUsual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show ofcal Examinar must be netfilled at 1 X Yes 2 No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examinating must be new 20904 USA 12325 NEW HAMPSHIRE AVENUE Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CONTACT REPRESENTATIVE FEDERAL GOVERNMENT 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOHN WESLEY MANNING ANNIE BETHEA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTAL R. GAINYARD/DAUGHTER 360 TUMBLEWEED PLACE WALDORF, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK : 02-19-2009 LANDOVER, MD of Funeral Ser 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 20746 DONALD R. 4308 SUITLAND ROAD SUITLAND, MD GRAY 23a. Part Lanter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only / ne , ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GRAM NEGATIVE ROD BACTEREMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPTIC SHOCK SEVERE SEPIS / Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Yea 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate ours after death.

eral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN ROAD 20910 SILVER SPRING, MD SUGANTHI ALAGARSAMY 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar arkad

DHMH 17 Rev 1/2001

09-01236 Darren Goods Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate	of Death	Re	eg. No. 200	9 0492
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Deat	h	3. Time of Death
VIEGICAI EXAIII	nei	Darren Goods  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	Month February 1	11, 2009 4c. County of Death	0834 hrs
		2317 East Lafayette Avenue	Baltimore		n/a	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  216-92-6803	If Under 1 Year If Under 1 Year Months Days Hou	rs Min. 8. Date of Bird	th(MM/DD/YYYY) 9. Birth	nplace (State or ntry) MD
J	•	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
and show a	L		imore			1 X Yes 2 No
laryland st once at once	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Count	try?
with the Maryland ns 23a or 28a-f sho		400 N. Lakewood Ave.	21224		USA	
leath wi	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	Vas Decedent of Hispanic Or Yes, specify Cuban, Mexica	rigin? ( Specify Yes or No- ın, Puerto Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
after death al", or iten	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify	y:	Specify: Bla	ick
hours matur Exam		during	ent's Usual Occupation (Give most of working life, DO NO		16b. Kind of Business/In	dustry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12th	Cook		Dank	
215-0036 be filed within 72 ttal Hygiene. Red other than "	Con	17. Father's Name (First, Middle, Last) William Goods, Sr.	18.Mothe	er's Name (First, Middle, N		
ttal ]	Be			tie mane		
MD 21; d 2 should;b tth and Men n 27 is marl	2		ng Address (Street and Nu 2 E. Belvedere			
ore, M of Health If item 2		20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery,	Date Date	20c. Location - City or T	own, State
		Burial 2 Cremation 3 Removal from State crematory or 4 Donation 5 Other Specify:	' '	Feb.20,200	9 Balto,Md	. •
Baltimore, permit. Pages I an Department of Hea Important: If ite		. Deficition of Care operation	Name and Address of Facility 110 B. Scrud	gs Funeral	Home	
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	112 E. Presto	n St. Balto	, Md. 2121	
Physician /Medical		failure. List only one cause on each line.	the mode of dying, such as	cardiac or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  Seizure disorder  Due to (or as a consequence of):				Death
		Sequentially list conditions, b. Head injury				
	nine	if any, leading to immediate Due to (or as a consequence of):				
sd sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit		X AMENDED #1per ME, #8,	per FH, #23a	a,2/,28a-f,p	erME, g889	3/26/09 TT
'60, cate be chysici		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
68760 certificate b nding physic se as the bu		Program at time of death		oic pregnancy	Month Da	ay Year
Box 687  the death certification in the attending in the as as the death of the dea	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
ires that the signed by the detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in F		bacco use contribute to the	
IS, P				1	2 No 3 Proba	42/11 12
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should t	Completed			24a. Was a autops	sy prior to co	opsy findings available impletion of cause of
tal Rec				1 <b>✓</b> Yes 2		2 No
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ing Phy After th		1 ✓ Yes 2 No 1 inpatient 2 ENOutpatien  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  (Month, Day, Year)		rk? 28d. Describe h	ow injury occurred	
ion ttendin death. tor: A	aţio	Natural 5 Pending Investigation 1/23/2003 9:50	am 1 Yes 2	Subject	fe11	
Division of Vital Records, P.O. Box 68 hin 24 hours after death certifinate hours after death.  The law requires that the death certificate has been signed by the attending npletely filled in by the funeral director, page 2 should be detached for use as	ertification:	Suicide 6 Could not be determined constitution of the constitution	eet, factory, office building, e	etc. 28f. Location (S or Town, St	treet and Number or Rure ate) 400 N. La re, MD	Route Number, City Rewood Ave
Lospita 4 hours funera	O	29a. Certifier 1 Contifuing Physician. To the best of my knowledge death as	urred at the time date and n			<del></del>
Divisic To the Hospital or Atte within 24 hours after dea To the Funeral Directo	ledical	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investig and manner stated.				
FFFS	Me	29b. Signature and title of certifier	29c. License number	r	29d. Date signed (Mont	
		Yandt Thuthall, mp	O.C.M.E.		February 12, 2009	<del>)</del>
~		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 1	11 Penn Street, Baltir	more, MD 21201		
St	ate	31. Date filed (Month, Day, Year) 2009 32. Figistrar's Signature	ake			

09-00903 Reginald Darnell			or Print in Bl of Maryland	/ Departr	ment of Heal	th an				20 0100
		1- For State Registrar	<u> </u>	Certiti	icate of Dear	h			g. No. 201	
Physicia Medical Exami		Decedent's Name (First, Middle,La	st)					2. Date of Death Month	Day Year	3. Time of Death 2106 hrs
Wedical Exami	ier	Reginald Darne 3 4a. Facility Name (if not institution, gi	1 Hester		Ab City	Town or	Location of Death	January 30	4c. County of Dea	1
		University Hospital	ve street and number)		Baltin		Location of Death		4c. County of Dea	un
Funeral		5. Social Security Number unk 6.5	Sex 7. Ag	e (In yrs. last b		er 1.Yea	r If Under 24Hrs.	8. Date of Birti	n(MM/DD/YYYY) 9. B	irthplace (State or
Director					Monti			7	Fore	
		Usual Residence of Decedent	M 2 F	56	Yrs.			Nov 5,	1952	
su au		10a. State 10b. County		10c. City, Tov	vn or Location				19	10d. Inside City Limits
. 6	_	MD		Ba1	timore					1 X Yes 2 No
arylar at on	Director	10e. Street and Number		L	10f. Zij	Code		10	g. Citizen of What Co	untry?
the Mail 10 r 28 iffied a	ä	3114 Chesterfie	ld Avenue				21213		IIC A	
26 C	era	11. Marital Status unk	12. Was Decedent	Ever in U.Su.	n] 13. Was Deced	ent of His	spanic Origin? ( Sp	ecify Yes or No-	USA 14. Race - Ame	rican Indian, Black,
death r Iten	nue	1 Never Married 2 Marrie	Armed Forces?	No	If Yes, spec	fy Cubar	n, Mexican, Puerto	Rican, etc.)	White, etc.	
after all", o	by F	3 Widowed 4 Divorce	d If Yes, Give Year		1 Yes 2	X No	specify:		Specify:	black
iours		15. Decedent's Education (Specify of	only highest grade com	npleted) 16	a. Decedent's Usual	Occupat	tion (Give kind of w	ork done unk	16b. Kind of Business	/Industry unk
6 n 72 h an "r	oleted	Elementary/Secondary (0-12)	College (1-4 or 8	5+)	Carring most of me			00,		
003 verthi	ompl		unk				40 Marks of North	(Fig. ) 6 days - 1		
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heakth and Mental Hyggene. Importants If item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once	ပ၂	17. Father's Name (First, Middle, Las	t)		u	nk	18.Mother's Name	(First, Middle, M	laiden Surname)	unk
212 buld be Menta mairke c even	o Be	19a. Informant's Name/Relationship (	Type Print )		19b. Mailing Addres	s (Stree	et and Number or F	Rural Route Num	per, City or Town, Star	e Zin Code)
MD 2 d 2 shou th and M a 27 is r		O.C.M.E.	7,50,	1 1		,				
and 2 N		20a. Method of Disposition		20b. Plac	e of Disposition (Na			Date	MD 2120 20c. Location - City of	r Town, State
Baltimore, permit, Pages I at Department of Hei Important: If ite		1 Burial 2 Cremation 3		10	natory or other place	:)				
it, Pa		4 Donation 5 X Other Specif			A2. Name and	Address	of Facility	1 (55 77	D 1.1	g
Ba Perm Depa injin	ļ	21. Si natur Fun Pricedice	wade our	ector			MD 2120		Baltimore	Street
Physician	$\dashv$	23a. Part I. Enter the disease, or com	plications that caused	the death. Do	not enter the mode	of dying,	such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on e	Unnorton	sive ca	ardiovascı	ılar	disease			Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		ildio vase.	- I CI	<del>dibease</del>			
		Sequentially list conditions,								
	Je	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):						
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xecuted n and - transit		events resulting in death) Last								
5 E E	lical	X UNPENDED	AMENDED 23	a,PII,2	7,permE,	g888	3 2/25/09	TT		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physteian; The law requires that the death certificate be exhibit 24 hours after death. Therefine the hear signed by the attending physician oppletely filled in by the funeral director, page 2 should be detached for use as the burial.	hysician/Medi	IF FEMALE:	23c. If yes, outcom	ne of pregnan	cy				23d. Date of delive	ry
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal death	3	Ectopic pregna	ncy	Month	Day Year
OX sath co	Sici	1 Yes 2 No 9 Unknow		time of death	5 Other (Spe	ecify)				
the de	된	Part II. Other significant conditions	9 Olikilowii	but not result	ting in the underlying	a cause o	given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
P.O.	þ	Astma COPD		, , , , , , , , , , , , , , , , , , , ,		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ymmen)		bably 4 V Unknown
ords, w require is heen sig	Completed	TIOCHIC GOLD						24a. Was a	n i 24b. Were a	utopsy findings available
SOFC law re has he 2 sho	휌							autops	y prior to	completion of cause of
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Division of Vital Records, rat or Attending Physician: The law requirms after death.  "In Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner?	Hospital:				Other			
n of Vit ling Physic After this (	유.	1 ✔ Yes 2 No	ı ınpane			JOA	4		Residence 6 Oth	er: 
n of ding Ph	삥	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Inju (Month, Day,Y	ear)	b. Time of Injury	_	ry at Work? Yes 2 No	Zou. Describe n	ow injury occurred	
Sior Mitend death death sy the	ertification:	2 Accident Pending Investiga	tion					206 1 1 10	The state of New York and New Y	and David Market Co.
Divisipitat or At ours after d	<b>[</b>	3 Suicide 6 Could no determine	be	jury - At home	, farm, street, factor	, office b	ouilding, etc.	or Town, St		ural Route Number, City
ospita hours mera y fille	0	20a Cartifier	(							
Divisior To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the	Medical	(Check only 1 Certifying Physic	cian: To the best of my er:On the basis of exar	_						
To t With To t	led led	29b. Signature and title of certifier	and manner stated.				e number		29d. Date signed (M	
		200. Signature and the of control	1. 1		, 29	O.C.I		WF	January 31, 200	
		Theodie !	y king	TAI.	an	J.U.		* 1 for	Caridaly 01, 200	···
		30. Name and address of person who Theodore M. King, Jr., MI				enn Sti	reet, Baltimore	e. MD 21201		
	7	31. Date filed (Month, Day, Year)	32. Registrar			J 1 Oli	. co., paramore	-, = 1201		
Sta Regist	_	51. Date filed (Month, Day, Year)	6	J. J.	Carried					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [9] 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** Februa 2000 UMT rances /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Deatl Examiner Burnie, Anne Medical Cent Glen Himore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month Day,
Month Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 20 F Maryland 20. 219-40-0326 NOV Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprainer must be neithed at any injury or other traumatic event, the Medical Exprainer must be neithed at any injury or other traumatic event, the Medical Exprainer must be neithed at any injury or other traumatic event. 1 □Yes 🙀 □ No Director Anne Arundel Brooklyn 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21225 4325 Cortez Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify: White ð 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12College (1-4or 5+) School Board Book Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Shift Lena Genovese ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4325 Cortez Road Brooklyn, MD 21225 Louis Hunter/Son 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/18/09 Baltimore, MD Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death cause on each li Immediate Cause (Final Shoc Physician Wer disease or condition resulting in death) /Medical Duy t (or as a consequence of): Examiner nemmonia Tion wee Sequentially list conditions, if any boding to in-mediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the t attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) Ó cate has been signed by the page 2 should be detached 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown Ver 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Compression 24a. Was an autopsy Hospital or Attending Physician: The certificate Coronam artery 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director, 26 Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral properties of death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only one) and manner stated. the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

31. Date filed (Month, Day,

0

32.

Registrar's Signature

Patient Known as Richard Hill
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			Please Type or Pr						-	•		
			1 - State of N Registrar	faryland / Department of Health and M Certificate of Death				fental Hygiene Reg. No. 2009 04926				
	Physician /Medical  1. Decedent's Name (First, Middle, Last)  Richard Alan Hill							2. Date of Death Month February	Day Yea	1 4 6 4 11		
	Examin	er	4a. Facility Name (If not institution, give street and number	4b. City, Town, or Location of Death 4c. County of Death					eath			
E	Funeral	tor	5. Social Security Number 6. Sex 7.	Age (In yrs.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	year) (	Sirthplace (State or Foreign Country)		
	d oth		Usual Residence of Decedent									
			MD Caroline 10c. City, Town or Location Federalsburg							10d. Inside City Limits 1 ☐ Yes 2 📉 No		
		Director	10e. Street and Number	10f. Zip Code				10	g. Citizen of What	Country?		
		eral	502 Liberty Road	at Ever in III	21632				U.S.A.	nerican Indian,		
036		To Be Completed by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Deceder  1 ▼ Yes 2 □  If Yes, Give Year or Dates	s? ] No	? If Yes, specify Cuban, Mexican, Puerto			o Rican, etc.)	Black, White, etc.  Specify: White			
15-0			15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			king	6b. Kind of Busines	ss/Industry			
212			Elementary/Secondary (0-12) College (1-40	r 5+)	Sales Consultant				Automotive			
Maryland 21215-0036			17. Father's Name (First, Middle, Last) Aaron G. Hill		18. Mother's Name (First, Middle, Unknown  19b. Mailing Address (Street and Number or Rural Route Numbe							
			19a. Informant's Name/Relationship (Type. Print) Peggy Hill/Wife			ailing Address <i>(Street</i> 2 Liberty				, Zip Code) L632		
Baltimore,	ages 1 and of He t; If Item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta	te (	cemetery, o	sposition (Name of crematory or other place	· i		20c. Location - City			
altin	permit. P Departme Importan any Injury once.		4X Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Allo		Gifts Registr 22. Name and Addre			lanover, N ts Regist			
e E	S a E S	١.,	7522 Connelley Drive, Ste.P, hanover, MD 2107									
	Physician /Medical Examiner pnulal-transit		23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  a									
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To		Examiner	cause. Enter Underlying Cause (Disease or Injury	as a consequence of):								
60,			that initiated events c.	is a consequence of):								
6876	ficate be physici s the bu	dical	d									
.O. Box	death certi e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □						23d. Date of delivery Month Day Year			
S, P	law requires that the de as been signed by the a 2 should be detached f	Completed by Ph	That is office agricultural contained in containing in the underlying cause given in Part i.									
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or Vital Records,	The law		Chronic Kidney Disease Diabetes Mellitus					perform	a. Was an autopsy performed? performed? Yes 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑No 2 ☑NO 2 ☑			
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n or	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	on: To	1 Yes 2 No Prospital 1 In Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?  28b. Time of Injury Work?									
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office						28f. Location (Street and Number or Rural Route Number,			
ă			4 ☐ Homicide building, etc. (Specify) City or Town, State)									
		Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner as stated.									
	To the within To the Comple		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  400  400  400  400  400  400  400  4									
1	٧		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John Steele MD Singi Hosnital of Baltimore									
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature											
Registrar  DHMH 17 Rev 1/2001  FEB 1 9 2009 June 1. Januar 1. Janu												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** enasc · ISAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5901 Lillyan Ave Baltimore Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-28-1926 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. Country) 1 M 2□ F 212-22-9552 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, it a floation Examiner must be refitted any energy. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1√2 Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 5901 Lillyan Ave 21206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify. Specify: African American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Unknown 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UnKnown ဂ္ Lillian G. Handy-Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lizzie Linton - case manager 10 N. Calvert Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 02-21-2009 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signar 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Col **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760.-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation n 24 hours after death.

Funeral Director; Afte fun by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 of Marylan & Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** 17 2009 11-35PM William . Helphenstine 222UARY /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE CIEN BURNIE BALTIMOZE DARHINGTON MEDICAL CENTR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 30, 5. Social Security Number 577-22-809 Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show ms 23a or 28a-f shov 1 ☐ Yes 2/☐ No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 27 Vista Avenue 21061 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any hjury or other traumatic event, The Medical Event Natural Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No White 2 Specify: 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Brewing Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clinton Helphenstine Ila Whitehill ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Scherry Belz/ Daughter 2508 Rehmeyer Hollow Road Stewartstown, PA 17363 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. Date 21, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, MD Glen Haven Mem. Park 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Servcies PA, 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUMONARY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) MI

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

and address of person who pleted cause of death (Item 23a) (Type, Print) 301

Registrar's Signature

DA

31. Date filed (Month, Day, Yeafr)

			For	State of	f Marylar		artment of H		Mental H	ygiene	9		
			1 - State Registrar Certificate of Death Reg. No. 2							2009	04929		
	Physicia	an	1. Decedent's Name (First, Middle, La William Harris	_					Month	Day		3. Time of Beath	
	/Medic		4a. Facility Name (If not institution, giv		mber)		4b City Town or	Location of Death	11	eguan i4 2009 1025 AM M			
	Examin	er	Union Memorial					Baltimor		"	N/		
	Funeral		5. Social Security Number 6. 5	Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of 8	Birth Day Year)	9. Birt	nplace (State or Foreign untry)	
	Director		212-44-7751	1 <b>⊠</b> M 2□F	60	Yrs.	Months Days	Tiouis IVIII.	Aug. 2		48 Ma	rýland	
and	f show	tor	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits	
Mary			MD N/A	<u> 4</u>			Baltin	nore				XXYes 2 □ No	
the	or 28a	irec	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	•	
th wit	tal Hygiene.  dother than "natural", or items 23a or 28a-f show event, if a Mydical Evaning must be notified at	Funeral Director	1721 N. Collir	igton A	venue			21213			US	Α	
r dea		nne	11. Marital Status	Armed Fo	edent Ever in U rces?	I.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Pu <i>e</i> rt	pecify Yes or I o Rican, etc.)	No-	14. Race - Ame Black, White		
S affe	", or i	by F	1 ☐ Never Married 2 ፟Married 1		2 □ No ve ates:	o 1 □ Yes 2 🛣 No Specify:					Specify: B	lack	
	atura cal E		15. Decedent's Education			16a. Decedent's Usual Occupation				16b. Kind of Business/Industry			
<b>6. 1.3</b>	ene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)				A & S			
7 J	ygien ier th		12th Grade				Fruck Dr					Company	
	Tand 2 should Health and Mer em 27 is marke ther traumatic	To Be	17. Father's Name (First, Middle, Last Richard Harris					18. Mother's Nan Bertha			Surname)		
~			19a. Informant's Name/Relationship (Type. Print) Kathi Harris/ Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1721 Collington Ave. Baltimore, MD 21213								, ,		
υ -			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	TD amount from	20b.	Place of Dispo cemetery, crer	sition (Name of matory or other plac	е)	Date	20c. Lo	ocation - City or	Fown, State	
Pages	ant: h		4 □ Donation 5 □ Other (Special				unt Cem.		3/09		timore	·	
Dall	Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee Oan	nes		2. Name and Addre 210 Belā					neral Hm. 21206	
			shock, or heart failure. List only one cause on each line.								Approximate Interval Between		
	hysician		Immediate Cause (Final disease or condition  Auth MysCardial Induction  Onset and Death  Ducley									Juleek	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):								1614		
		er	b. Conceptue Heart failure  b. Conceptue Heart failure  Due to for as a consequence of):									10920	
- E	d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							en 10-15%		2 weeks	
C, C	physician and s the burial-transit	Exa	resulting in death) Last	Due to	(or as a consec	quence of):		0					
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والأرق	ling pl	Med	IF FEMALE:	00.15									
DOX	attend for us	sician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of				tal death 3 Ectopic pregnancy			23d. Date of de Month		very Day Year	
. §	y the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										
, ŧ	ned by	y Phy	Part II. Other significant conditions	ditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Di	23e. Did tobacco use contribute to the cause of death?			
Records he law requires	n sign	ed by							1 [	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown			
	as bee	Completed							24a. W	as an topsy	24b. Were au	topsy findings available completion of cause of	
<u> </u>	ate ha	mo:							pe 1 □ Yes	rformed?	death?	2 No	
VITAI	ertific ector,	Be C	25. Was case referred to medical examiner?  26. Place of Death (Check only one)										
OT V	this c al dire	ျ	1 ☐ Yes 2 ☑ No									cify)	
	to the Hospital of Attending Physician: The law requires that the death cernit within 24 hours after death. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Certification:	1 ✓ Natural 5 □ Pending (Month, Day, Year) Injury Work?							8d. Describe how injury occurred			
DIVISION Lor Attending		fical	2 Accident							(Street ar	Street and Number or Rural Route Number,		
ב <u>ּ</u>		Serti	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							City or Town, State)			
Hoenit		Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Ę.	vithin To the compl	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Month	n, Day, Year)	
			Martine	Ben	nod	- M.	D, AT	24389	146	Elb	mary,	14 2009	
	5		Martine Blensed M.D. AT J438946 February, 14 Joo 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Martine Bernard M.D. Umon Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John Memorial Hospital Ballinure M. D. John M. D. John Memorial Hospital Ballinure M. D. John								livere MI)		
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 9 2009	32. F	Registrar's Sign	ature	1			/	/ 5		
-			EED TO COOS	Lond of the same	-	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marv Elizabeth Geary Hartley 17, 2009 5:59 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 12, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 😿 F Mary land 215-12-1127 93 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at MD Baltimore 1 ☐ Yes 2 ☑ No Director Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 11630 Glen Arm Road 21057 U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ∐Yes 2 DXNo Specify þ Specify: White Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Homemaker Own home is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Napfe1 Mary Joseph Katherine Pau1 ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trauonce. William Humphreys-attorney 611 Braeside Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 2/20/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William Dau G. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 20 MIN /Medical Due to (or as a consequence of): Examiner Eague, Itially not our officers, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (onas a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗀 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 9 DUnknown isigned by ti 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s certificate 2 🗆 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Hame 5 Residence 6 Other (Specify) 1 ∐Yes 2 🗹 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 1 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date sighed (Month, Day, Year)

State Registrar 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NNE

32 Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 JONES **Physician** IWM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 840 Singing Hills Court Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y)
July 31, 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Year Days Hours 141-26-3572 73 1935 New Jersey **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widest Executary Instruction once. 1 ☐ Yes 2√☐ No Director Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 840 Singing Hills Court 21401 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No white Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 5+chemistry professor US Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Owen Kenyon Jones Ruth Braxton ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanne C. Jones/spouse 840 Singing Hills Court Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Fineral Strate Icensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREAS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

e Funeral Director: Af eletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Detifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f (Check only one) and manner-stated. To the

State Registrar 29b. Signature and title of dertifier

2. Registrar's Signature 31. Date filed (Month, Day, Year) askend

person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

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29c. License number

29d. Date signed (Month, Day, Year)

DEFENSE HIGHWAY ANNAPOUS MOZING

February 11, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician AMO 02 2000 /Medical acility Name ot institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Year) -12-27 Days Hours Min. 1 ☐ M 2 🗹 F Director may Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State r than "natural", or items 23a or 28a-f show Yes 2 No Funeral Director Pages 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ðγNο amo ed other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked other traumatic ev Denni Ja 1a ည 19a. Informant's Name/Relationship (Type. Print) ( range 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hater St Balto.md. Wallow Clauditer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Zeon 4 Donation Ø Dother (Specify) 21. Signature of Fineral Service Licenses 22. Name and Address of Facility 23a. Part I Enjecthe disease, or complications that caused the death. Do not enter the mashock, or leart failure. List only one cause on each line. e of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 100 After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknow significant conditions contributing to death but 23e. Did tobacco use contribute to the cause of death? \$ 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 ☐ Yes 2 🗷 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 110 Certification: To 2 ER/Outpatient 3 DOA y \_\_\_inpatient 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif ath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29c, d pr dr., g888, 02/19/09dhb certificate of Death Reg. No. For State Registrar 04933 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** RICK Kos micki 12147 PN Gn 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Homewood Baltimore CTenes is If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F 47 Yrs Jan 6, 1962 210-52-4600 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1√Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Bellona Avenue 21212 USA Funeral filed within 72 hours after death ! Hygiene. 12. Was Decedent Ever in U. **unk**Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation unk unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Genesis Homewood 600 Bellona Avenue Baltimore, MD Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other(Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronal of S. Wad Director 21 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Huntington Chores **Physician** disease or condition resulting in death) errs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 🗌 Yes 2 1No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has the funeral director, page 2 autopsy performed 1□ Yes 2 PINO or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 Certification: To 1 ☐ Yes 2 ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 □ No investigation 2 ☐ Accident Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31295 February 19, 2009 News 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21206 100002 701 Kemwood 13 action ore MD 31. Date filed Month, Day, Year) 32. Registrar's Signature State Jarks Registrar FFR 1 9 2009

			For State Registrar	State of Ma	ryland	-	rtment of H tificate of I	lealth and N Death	nental Hyg ı	giene Reg. No. 2 (	009	049	334
Alej			Decedent's Name (First, Middle, Last)						2. Date of Dea		Year	3. Time of	Death
	Physicia /Medic	_	Oscar Meredith I						Feb. 16	2009		5:47	$P^{M}$
	Examin	er	4a. Facility Name (If not institution, give str					Location of Death			ty of Death		
	· · · · · · · · · · · · · · · · · · ·		8810 Walther Blvd.  5. Social Security Number 6. Sex		(In vrs. la	ast birthday)	Parkv If Under 1 Year	ille If Under 24 Hrs.	8. Date of Birt	h	altimo		r Foreian
<i>:1</i>	Funeral Director			1 2□F	77	Yrs.	Months Days	Hours Min.	Sept. S	v, Year)	Mar	lace (State or htry) yland	7 0 10 19 17
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	or 28%	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	itry?	
	23a c	ral	8810 Walther Blvd				21234				SA		
	tems rer m	Funeral	TT, Walter Oldico	. Was Decedent E		5.   13. \	Vas Decedent of H FYes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. H	ace - Americ ack, White,		
0000	should be filed within 72 hours after death with the Maryland nod Mental Pygiene. Inaked other than "hatural" or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	0	'	☐ Yes 2☐No	Specify:		Spec	ify: W	nite	
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Š	hould d Mei mark matic	우	19a. Informant's Name/Relationship (Type	Print)		19b. Mailin	a Address (Street	and Number or Rui			n. State. Zic	Code)	
<u>0</u>	Ith an		L. Jeannine Keys/W			8810	Walther	Blvd. #31	23 Park	ville.	MD 2	1234	
ก	s 1 ar f Hea item 3		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of	Ĭ .		20c. Location			
altimor	Page nent o ant: If ary or		1 X Burial 2 □ Cremation 3 □ Read 4 □ Donation 5 □ Other (Specify)	noval from State	More Pa	eland rk Cen	natory or other plac Memorial netery	200	9	Park	ville,	MD	
Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dejarment of Health and Mental Hygiene. Inportanent of Health and Mental Hygiene. Inportant: If the Z1 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Selvice Linense	ael J. Fl	agle	Le	Name and Addre	ss of Facility eral Home nia Road	of Dul	aney V	alley	Inc.	
								ng, such as cardiac			2109.	Approximate Interval Betv	
	Physician		Immediate Cause (Final disease or condition				4	1				Onset and D	
	/Medical		resulting in death)	Lue to (or as a	consequ	ience of):	ma o	colon				7-	473
	Examiner		Sequentially list conditions. b.										
	St Visi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ience of):							
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00	tificate g phy as the	ledical	u.										
gox	th certi ending r use a	an/N	236. was decedent pregnant	o. If yes, outcome p 1 ☐ Live birth = 2			Ectopic pregnancy	/			Date of delive	•	/one
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<u></u>	ding Ph n. After th funeral	uc.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day		28b. Time of Injury	28c. Injur Wor	ry at rk?	28d. Describe I	now injury occ	urred		
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$\leq$	or At after d Direc in by	Certification:	4 Homicide determined	28e. Place of inju- building, etc.	ry - At no . (Specify	me, rarm, str	еет, тастогу, опісе		28f. Location (S City or Tox		nber or Rura	il Houte Num	ber,
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	To the within 2 To the comple	Medical	29b. Signature and title of certifier	and manner stat	ted.		29c. Licens	e number	_	29d. Date sign	ned (Month,	Day, Year)	
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DHMH 17 Rev 1/2001

Amend 4b per MD & 15, per FH g888 2/19/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 9/5AM tegruar /Medical Examiner Town, or Longition of Dath stown 4c. County of 0 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 01/03/1925 **Funeral** 9. Birthplace (State or Foreign Months Days 1 X M 2 □ F Hours 84 BELARUSSIA 216-45-4159 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or nitems 12a or 28a-f show any or other traumatic event, Ira Medical Experiment mast be notified at 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 WOODTURN COURT, #7 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ 1 ☐ Yes 2 📉 No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOBILE MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DANIEL KHAZANOV ဥ SARAH ZOLOTAREVA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOYKA POPOVA / WIFE WOODTURN COURT, #7 OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 02/18/2009 | REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final shemic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 043011 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 23e. Did tobacco use contribute to the cause of death? ş icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2**1** № No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \(\sum \) Nursing Home Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death ate of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day, Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tixt of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type) Print)

Registrar's Signatur

9-01243		Please Type or						egible		
racy Robert Kin		0.0.0	of Maryland	•		alth and Menta	l Hygiene			
		1- For State Registrar		Certifica	ate of Dea	ath		Reg. No.	200	3. Time of Death
Physicia	n/	1. Decedent's Name (First, Middle,Last)					2. Date of D	eath	200	3. Time of Death
Medical Examii	ner	TRACY DONNELL K	INCHEN				Month Februar	y 11, 20	Year 09	1206 hrs
Para San		4a. Facility Name (if not institution, give	street and number)		4b. City	, Town, or Location of I	Death		County of Death	1
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Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birt	• •	nder 1 Year If Under 2		Birth(MM/D		thplace (State or
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2121 old be fi Mental I marked	O B	ALPHONSO CARTER  19a. Informant's Name/Relationship (Type	ne Print \	1 101	Mailing Addre	ss (Street and Number	RA LYNN K	CINCH!	EN State	Zin Codo\
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and 2 ≥	- 1	CLEMMIE T. RAMS	EY (MOTHER			35th ST. BA	LTIMORE Date		LAND 2 Jocation - City or	
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im Pag Pag ment lant:		4 Donation 5 Other Specify		KING	MEMORIA	L PARK 2	2-16-2009	BALT	CIMORE.	MARYLAND
Baltimore permit Pages I Department of I Important: If	- [	21. Signature of Fall eral Survice Licens	JONATHAN	D. HIB	N R Name ar	nd Address of Facility	HILLIPS E	UNERA	AL HOME.	P.A.
E.E.E		Touth a	). / XU	3						RYLAND 21217
Physician		23 . Part I. Enter the disease, or complice failure. List only one cause on each		the death. Do no	t enter the mode	e of dying, such as card	iac or respiratory	arrest, shoo	ck, or heart	Approximate Interval Between Onset and
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Box e death c the atten	Ş	1 Yes 2 No 9 Unknown	9 Unknown		Out (-)					
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Division ospital or Attenchours after death hours after death meral Director: y filled in by the	티	4 V Homicide determined	(Specify) Alle	ey			1700 East 3	, State) 2nd Stree	et, Baltimore,	MD
D Hospital 24 hours Funeral tely filled		29a. Certifier 1 Certifying Physician	n: To the best of my	knowledge, dea	th occurred at t	he time, date and place	, and due to the ca	use(s) and	manner as stat	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: 0	on the basis of exar							
F 3 F 8	Me	29b. Signature and title of certifier	nd manner stated.		2	9c. License number		29d. D	ate signed (Mo	nth, Day, Year)
		Dan 101 11 1	446			O.C.M.E.			uary 12, 200	
		7 WMW T WITHUIT	M()	ooth (lines 00-)					, , , = 0,	
L .		30. Name and address of person who co Pamela E. Southall, MD	mpleted cause of d Assistant Medi	,	111 Pen	n Street, Baltimoi	e MD 21201			
7) V			32. Registra		-		U, 1712 E 1201			
Sta	ite	31. Date filed (Month, Dan Year)	32. Registral	a alguature	- 10 0					

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death C. LIPSCOMB EBRUARY 13,2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTI BALTIMURE REHABILITATION EXTENDED CARE Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Sex 1X M 2□ F Months Days Hours 81 M 215-22-9155 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4107 Handvell Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes ≥ □ No If Yes, Give Year or Dates: 1950–1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify specifyAfrican-American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Bethlehen Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lipscomb Mary Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roslyn Corbin / Daughter 4107 Handwell Road Randallstown, Maryland 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Carrison Forest VA Cenetery 2/20/2009 4 Donation 5 Dother (Specify) Owings Mills, Maryland 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. ture of Funeral Service Licer andlan 9200 Liberty Road Randallstown, Maryland 21133 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) URE TO Due to (or es a consequence of): Sequentially list conditions, and letter of the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OSTED MYELITIS, RIGHT FOO 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Unknown OF THE 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

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**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner muonce.

Baltimore, Maryland 21215-0036

certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran

P.O. Box 68760,

Examiner Physician/Medical Completed

Be Certification: To

Medical

The law requires that the death certificate be executed Division of Vital Records, Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> 3+1 State Registrar

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident 3 Suicide

4 Homicide

29a. Certifier

5 Pending investigation 6 □ Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

autopsy performed? 1 □ Yes 2 No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

29b. Signature and title of certifier huma

and manner stated

Hospital:

29c. License number

BULLEVARD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 1 9 2009

00 LOCH 32. Registrar's signature

			Pleas  1 _ For State	e Type or I State o	Print in E f Marylan	d / Depa	artment	of F	lealth	and N	-	ygier	ne		01.00
			Registrar  1. Decedent's Name (First, Middle,	( act)		Cei	rtificate	OI I	Deam		2. Date of D		No. 20		<u>U493</u>
	Physici /Medic		James Edward Lo	·							Month Febru		14 20	'ear	Time of Death 5:50 PM
	Examir		4a. Facility Name (If not institution, g Gilchrist Hospi		mber)		4b. City, To		Location	of Death			4c. County of Baltim		
	Funeral Director		-	Sex 1 M 2 □ F	7. Age ( <i>In yrs</i> . 52	last birthday) Yrs.	If Under 1		If Under Hours	24 Hrs. Min.	8. Date of B (Month, D 08/19/				(State or Foreign
	T		Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo	cation				00/19/	T90	0		nside City Limits
	ne Maryl :8a-f sho	ector	MD		Balt	imore								1	XYes 2 □ No
	th with the 23a or 2	Funeral Director	10e. Street and Number 5965 Pimlico Ro	ad, Apt.	1		10f. Zip C	ode 120	9			10g. (	Citizen of Wh		
5-0036	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Modical Exercitive must be rediffed at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☎ Divorced	Armed Fo	2 □ No ⁄e		Was Deceder f Yes, specify I □Yes 2		ispanic Or in, Mexical Specify.		ecify Yes or N Rican, etc.)	0-	Black,	American In White, etc. Black	
21	vithin 72 ho rne. <b>.han "natur</b> e Medical	Completed	15. Decedent's (Specify only highest ( Elementary/Secondary (0-12)		-4or 5+)	(Give life. I	dent's Usual kind of work DO NOT use	done d retired	during mos I)	st of work	ing	1	Kind of Busin	,	1
Maryland 21	should be filed within and Mental Hygiene. s marked other than ' umatic event, Its Me	To Be Co	17. Father's Name (First, Middle, La Edward Blake	st)		Secui	ity O		18. Moth		e (First, Middle		overnme en Surname)	ent	
	s 1 and 2 should be to Health and Menta item 27 Is marked other tranmatic ex		19a. Informant's Name/Relationship Edward Blake/Fa								al Route Num tersvi			ate, Zip Codi 23083	e)
altımore,	Pages 1 ament of He ant: If item ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		State	Place of Dispo cemetery, crem CMY Gift	natory or others. S Regis	er piac stry	C	2/19	) 2009	Har	Location - Ci	Maryl	
Balt	permit. Pages Department of Important: If ii any injury or once.		21. Signature Funeral Service Lic	engle							tomy G e, Ste				21076
	Physician /Medical		23a. Part1. Enter the diseas. In the shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ENT	STA	GE K	ENP	TL	DI	58	SE			Inter Ons	roximate rval Between et and Death
S. C. C.	be executed cian and cian and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>PRIM</u> Due to (	or as a consequence or a consequence or a consequence or a consequ	uence of):	3RA	101	IS N	1ef	HRO	PAT	H4_	(	jeas
09/89	cate be	cal	•	d											
O. Box 6	the death certificate be executed by the attending physician and sched for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 ☐ Feta nant at time of o	Ideath 3	Ectopic pred Other (spec		/				23d. Date of Month		Year
ds, P.	w requires that the d been signed by the should be detached		Part II. Other significant conditions  Rectal _ Call	contributing to de			nderlying cau	se give	en in Part I	•			o use contribi	ite to the cau ☐ Probably	use of death?
ပ္မ	slcian: The law req certificate has beer irector, page 2 shoul	Completed by	metastatic	cance	r of	cul	now	n	·DVI	nery	24a. Was		pric	r to complet th?	ndings available ion of cause of
E	cian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	1 ∐Yes ∩ (Check only		70 IL	Yes 2□	NO
_	<b>₹</b> ₩ ₽		1 Yes 2 No		npatient 2	<u>:</u>		Othe	4 🗀 NI		me 5 ☐ Res			(Specify)	OSPICE
LOIS	ending Physisath.  or: After this can be funeral directory.	ation	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigat	on	h, Day, Year)	28b. Time of Injury	M 280	. Injury Work 1 🔲 ነ	yat ?? Yes 2□		28d. Describe	how inj	jury occurred		
DIVISION	tal or At s after d al Direct ed in by	Certification: To	3 ☐ Suicide 6 ☐ Could not determine	a Zoe. Place	of Injury - At hong, etc. (Specif	ome, farm, stre y)	eet, factory, o	ffice			28f. Location City or To	(Street a wn, Sta	and Number ate)	or Rural Rou	te Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	ledical (	29a. Certifier (Check only one)  Certifying  2 Medical Ex	Physician: To the aminer: On the ba	asis of examina	wledge, death tion and/or in	occurred at vestigation, in	the tin	ne, date ai pinion, dea	nd place, ath occur	and due to the	e cause , date a	e(s) and manr and place, and	er as stated I due to the o	cause(s)
	Vomp	Me	29b. Signature and title of certifier		) AA	^	-		number	11		29d. E	Date signed (/	Month, Day,	Year)
			Xendal	RH	rell	luc	1 6	10	156	ナン	2	0	0/14	1200	29

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lendall Regulary WD/555 W. T

Towsartown Blud/Balto MD 21204

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month James Edward Lewandowski February 17, 2009 6:35 pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Essex If Under 1 Year | If Under 24 Hrs. Baltimore Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1**X** M 2□ F 220-05-9953 5/6/1921 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 339 Homberg Avenue 21221 S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No 1946, Give 1947 Year or Dates: 194 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married 1942 1 ☐ Yes 2X No 3 Widowed 4 Divorced Specify: 1946 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western Electric 9 Machine Setup Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zygmore Lewandowski Helen Harnek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna R. Lewandowski (Wife) 339 Homberg Avenue Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 02/21/2009 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) SCHEMIC HEART DISEASE Due to (or as a consequence of): STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TYPER FENSION Due to (or as a consequence of): 2 RHOEA IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Injury at Work? 1X Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, hed by the detached signed by page 2 should be has been certificate completely filled in by the funeral director. Hospital or Attending Phys 24 hours after death. Funeral Director, After this

**Physician** 

/Medical

Examiner Physician/Medical à Completed Be Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be presented.

Baltimore, Maryland 21215-0036

24 hours a

State Registrar

Medical

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a, Certifier (Check only one)

determined

19 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fh g889 3/26/09 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Pay 16 2009 **Physician** Joseph V. Lamartina, Sr. /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE Anne ADTIMORE NACHMICTEN MEDICAL CRITTER HEUNDE | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. | 10, Social Security Number 219-04-1504 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral X**□M 2□F 91 Colorado Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mydical Evantiest roust be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2913 Kingsley Street 21223 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Lamartina Adelena Gabro ဂ္ 19a. Informant's Name/Relationship (Type. Print)

Joan Darlene Kratz - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
55 Randall Avenue, Halethorpe, MD 21227 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2-19-2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 1. Signature of Funaral Service License 22. Name and Address of Facility Ambrose Funeral Tome, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANEUMO NON **Physician** /Medical Due to (or as a consequence of): Examiner CBSTRECTIVE FULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific

State

DHMH 17 Rev 1/2001

To the I within 2

certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

amarting, Joseph

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** FEBRUARY 3:35 PM DOROTHI LOTER 2003 /Medical 4a. Facility Name (If not institution 4c. County of Death give street and number) 4b. City, Town, or Location of Death **Examiner** RANDALLSTOWN NONTHWEST HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🗓 F **Director** 577-12-1129 90 MARCH 7, 1918 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Weddell Expr. Investigate to a confident at Yes 2 □ No Director MD ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1815 LANSING ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH NURSE ST ELIZABETH'S HOSP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM POOL NELLIE ISNER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM L. PUMPHREY / SON 1815 LANSING ROAD GLEN BURNIE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02-20-2009 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY SUITLAND, MD 21. Si nature d'un rus rivice dio nsee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 23a. Part 1/Ent -: the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocl, or heart failure. List enly one cause on each line. Approximate Interval Between Onset and Death immedia - Cruse (Final disease of ondition resulting in death) PNFU MONIA **Physician** /Medical Due to (or as a consequence of): Examiner DEMENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical the the 88 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ъ 1 Yes 2 No 3 Probably 4 Punknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ₩ No 1 ☐ Yes 2 No Physician: this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∏No 1 Enpatient 2 ER/Outpatient 3 DOA Certification: To eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C
completely filled 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

NORTHWEST

FEB 1 9 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MinctA Tobok

Registrar's Signature

29c. License number

HOSPITAL 5401 OLD COURT ROAD RANDALISTOWN

054352

29d. Date signed (Month, Day, Year)

17 2009

21133

		For State	State of N	/larylan	•	artment rtificate			and M	•		0000	01.	01.2
		Registrar  1. Decedent's Name (First, Middle, La	nst)		06	rincate	01 0	calli		2. Date of Dea	Reg. No.	003	3. Time o	of Death
Physicia		Sandra F. Marti								Februa:	ry 5.	2009 ear		РМ м
/Medic Examin		4a. Facility Name (If not institution, gi		er)		4b. City, To	wn, or L	ocation o				ounty of Death	1	
-		Upper Chesapeak	e Medical	Cente	er		1 A	ir			H	arford		
Funeral Director		217-44-2510	Sex 1 □ M 2 🔀 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months [	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da July 29	, Year) 94	9. Birth	place (State intry) yland	or Foreign
and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside (	City Limits
ith the Marylar or 28a-f show	ţo	MD Harfor	·d		Forest	Hill							1 □Yes	s 2X No
h the	Director	10e. Street and Number				10f. Zip C	ode				10g. Citize	n of What Cou	intry?	
th wil	ral	109 Forest Valle	y Drive					2105				USA		
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Meanal Hygiene.  The file of the filed within 72 hours after death with the Maryland of Health and Meanal Hygiene.  The file of the fil	by Funeral	11. Marital Status  1 ★ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give Year or Dates	§? No		Was Deceder If Yes, specify 1 □ Yes 2 ∑		panic Orig , Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	ì	. Race - Amer Black, White pecify: Wh	etc.	
72 hou	eted	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual (	Occupat	tion	of workin	a l	16b. Kind	of Business/li	ndustry	unk
ithin he.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use	retired)	_	<i>0. 11011111</i>	9				
Hygie Hygie Ither th		12 17. Father's Name (First, Middle, Las	0			secret			r's Name	(First, Middle,	Maiden Sı	ırname)		
d be f ental ced or	To Be	Sterling Irwin So								awkins		,		
2 should be filed withing and Mental Hygiene. is marked other than aumatic event, the	F	19a. Informant's Name/Relationship			19b. Maili	ng Address (S	Street ar			Route Numbe			p Code)	
and 2 ealth a m 27 is		Sterling Solomon	n/father		902 M	ſacPhai	1 W	ood C	cross	ing Bel	l Air	, MD 2	21015	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special Contents)			Place of Disponentery, crea	osition (Name matory or othe	of er place,	)	Da	ate	20c. Loca	tion - City or T	own, State	
permit. Departi		21. Signature of Fineral Service Lice Ronald S	wade. Di	rector		2. Name and A				655 tJ	0-1-		0	
40 E # 9		smill!	we we		B					655 W.		TIHOLE		
Physician		23a. Part 1 Enter the dise se, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			PSW	ter the mode (	or aying	, such as	cardiac oi	r respiratory ar	rest,		Approxima Interval Be Onset and	etween
/Medical Examiner		resulting in deathy	Due to (or a	as a consequ	ence of):									/
	ē	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b Due to (or a	as a consequ	uence of):							-		
cuted	Examiner	Cause (Disease or injury that initiated events	С.											
s be executed sician and burial-transit		resulting in death) Last		as a consequ	uence of):									
the type	dical	•	d											
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcon 1  Live birth 4  Pregnan 9  Unknown	n 2 ☐ Feta t at time of d	I death 3[	⊒Ectopic preç ⊒Other <i>(sp</i> ec					230	d. Date of delive	ery Day	Year
that the		Part II. Other significant conditions	contributing to death	but not resi	ulting in the u	nderlying caus	se giver	n in Part I.		23e. Did to	bacco use	contribute to	the cause of	death?
quires t	ed by	Houte Re.	nal	tau	UK	<u>.                                    </u>				1 🗆 Y	es 2	No 3□ Pro	bably 4□	Unknown
	Completed					····				24a. Was a autop perfor 1 🗆 Yes	sy	24b. Were aut prior to co death? 1 ∐Yes	opsy findings ompletion of 2 \(\square\) No	available cause of
Physician: T this certifical	Be	25. Was case referred to medical examiner?	Hospital:				Other			(Check only or	•			
Phys rr this	5.7	1 Yes 2 No 27. Manner of Death	28a. Date of it	njury	ER/Outpatie	nt 3 DOA	1	4 🗀 Nur		ne 5 Resid			ify)	
Attending Phrideath. ector: After thi	tior	1 Natural 5 Pending 2 Accident investigation	(Month, I	Day, Year)	Injury	м	. Injury Work? 1 □ Ye	es 2∐N	- 1		,,			
al or Atte s after des il Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined.		njury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, o	ffice		2	8f. Location (S City or Tow		Number or Run	al Route Nur	nber,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fur	Medical (	29a. Certifier (Check only one)  Certifying P  Certifying P	hysician: To the be miner: On the basis and manner	of examina	wledge, deat tion and/or in	th occurred at ovestigation, in	the time	e, date and inion, deat	d place, a	and due to the o	cause(s) a date and pl	nd manner as ace, and due	stated. to the cause(	s)
To tl withi To tl	Ž	29b. Signature and title of certifier	a Cau	uel	es k	29c. L	icense	number 454	109	4	F.h.	signed (Month	Day, Year)	1009
		30. Name and address of person who		death (Item	23a) (Type,	Print)	Rd	.Su	te	206 I	30/1	tic.mo	210	14

State Registrar

			1- State of Maryland / Department of Health an Certificate of Death	nd Mental		2 0 C	9	04943
	Physici		1. Decedent's Name (First, Middle, Last) Sheila Ann Moody-Rowley	Mon	of Death th 2 - 05 -	Day 2009	Yeer	3. Time of Death 2016 P M
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of C 410 West Bel Air Avenue Apt. 3 Aberdeen			4c. County		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		of Birth	Harfo		place (State or Foreign
	Director		Usual Residence of Decedent	08-	<sup>th</sup> 2 <sup>Day,</sup> Y	954	9. Birthi TN	,
	anyland show dat	يا	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28e-f	recto	Maryland Harford Aberdeen  106. Street and Number 10f. Zip Code			j. Citizen of V		ntry?
	ath with	Funeral Directo	210 West Bel Air Avenue 21001	2.40				es of Americ
036	i within 72 hours after death with the Maryland liene. I than "natural", or Itema 23a or 28e-f ehow Ite Medical Examiner must be notified at	by	11. Marital Status  1	n? (Specify Yes Puerto Rican, et	or No- c.)		ck, White,	
215-0036	"natur	leted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working	16	b. Kind of B	usiness/in	dustry
212	O 01 a -	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Disabled			Disab	led	
and	ild be filed lental Hygir ked other ilc event, I	Be		s Name (First, M U Jean			10)	
Maryland	and M	P_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of				State, Zij	code)
	1 and Health em 27 ther tr		Shasta J. Moody (Sister) 241 Windsor Court, S	Spring Date		TN c. Location -	City or T	own. State
altimore,	Pages nent of int: if it ury or o		1 □ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 ☒ Other (Specify) in State				,	
Balt	permit. Pages Department of Important: If if any injury or once.		21. Signature of Emeral Service Licensee Ronald S. Wade, Director State Anatomy Book Baltimore, MD 2		W. E	Baltim	ore S	Street
			23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.		tory arrest			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	n ac	eid	ent		Onsor and Dodan
ŀ	Examiner	_	Sequentially list conditions, b. CIVTENOS Clarte Ca	ndrovo	scul	n du	ano	
	uted d ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events causing ideath) last					
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68760		fedical						
ROX	death certifi e ettending od for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1				te of delive	ery Day Year
Р. О.	0 0 0	hysic	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 9 ☐ Unknown					
	The law requires that the ite has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e.				he cause of death? bably 4 Denknown
Records,	law require as been slo 2 should b	Completed		24a.	Was an autopsy	24b. 1	Were auto	opsy findings available ompletion of cause of
E B					performe Yes 2.	d?	death? 1 🗌 Yes	
<u> </u>	> 0 0	To Be	25. Was case referred to medical examiner?  1 Yes 2 TIM6  Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursi	f Death (Check ing Home 5		e 6 □Oth	er (Specil	(y)
0 0	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Des		injury occurr		
Division of Vital	or Attending after death. Director: Aftel in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loca	tion (Stree or Town, S		er or Rura	al Route Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical Ce	29a. Certifier  (Check only one)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and properties of examination and/or investigation, in my opinion, death and manner stated.	place, and due t occurred at the	o the caus	se(s) and ma and place,	inner as s and due to	itated.
	To the within 2 To the comple	Med	29b. Signature and title of certifier 0 1 29c. License number		29d	. Date signed	d (Month,	Day, Year)
				915		2	101	09
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CARAS - S. Nor R. M. O. B. O. S. Union  31. Date filed (Month, Day, Year)  FEB 19 2009  Separation Description of the person who completed cause of death (Item 23a) (Type, Print)  32 Registrar's Signature  A. Date filed (Month, Day, Year)	aue.	lod	ga ce	md	21078
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 1 9 2009 32 Registrar's Signature FEB 19 2009					

09-01352 Kathleen Vivian Qui	Please Type or Print in Black Indelible nn Moloney State of Maryland / Departmen	le Ink. Ensure All Copies Are Le at of Health and Mental Hygiene	
	1- For State Certificate Registrar	o of Doath	Reg. No. 2009 0494
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Kathleen Vivian Quinn Moloney	Month February	15, 2009 Year 1924 hrs
	4a. Facility Name (if not institution, give street and number) 70 Eastbound @ Mt. Phillip Road	4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 072 – 58 – 58 31 1 M 2 X F 49	Months Days Hours Min	oirth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
nd nd show any oce.		cott City	1 Yes 2 X No
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at oucc. Completed by Funeral Director	10e. Street and Number	10f. Zip Code 21042	10g. Citizen of What Country?
with the ms 23a of be notif		3. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.
	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: White
hours aft matural' Examine	lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	cedent's Usual Occupation (Give kind of work done ing most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hour bygiere than "nation the Medical Exar Completed	Elementary/Secondary (0-12)	ftware Engineer	Defence Contractor
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiène. Inner: If iren 27 is marked other than "natural", or other traumatic event, the Medical Examiner.  To Be Completed by I	17. Father's Name (First, Middle, Last)  James R. Quinn	18.Mother's Name (First, Middle Vivian Wolc	
D 2121 should be fi should Mental I is marked ratic event, To Be	19a. Informant's Name/Relationship (Type, Print )	Mailing Address (Street and Number or Rural Route N	umber, City or Town, State, Zip Code)
e, MD; I and 2 shou Heaßh and I Fitem 27 is in traumatic	20a. Method of Disposition 20b. Place of D	28 Rolling View Court Ell Disposition (Name of cemetery, or other place)  Date	20c. Location - City or Town, State
Baltimore, permit, Pages I at Department of Hee Important: If ite	4 Donation 5 Other Specify: Metro	Crematory Inc. 02/17/09	Baltimore, Maryland
Baltimo permit. Page Department Important injury or ot	21. Signature of Funeral Service Licensee  Thomas Gregor Jumes Survey	ਟਿਆਕਿਟਿਓਜਿ°S5ਦਿੱਦਿty Of Mar 299 Frederick Road Balti	yland, Inc. more, Maryland 21228
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory a	rrest, shock, or heart  Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Multiple injuries  Due to (or as a consequence of):	3/1	Book
Jer Jer	Sequentially list conditions, if any, leading to immediate	1 Test 1 - 0 15	11=
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68760, certificate be exending physician see as the burial -	IF FEMALE: 23c. If yes, outcome of pregnance 23b. Was decedent pregnant in the	me g893 7-28-09 vt    Fetal death	23d. Date of delivery  Month Day Year
eath c atten for us	past 12 months?  4 Pregnant at time of death 5	Other (Specify)	
s, P.O. Be irres that the de ir signed by the detached f	Part II. Other significant conditions contributing to death but not resulting in	Talo diladilying dated giranii i arii	tobacco use contribute to the cause of death?  (es 2 V No 3 Probably 4 Unknown
cords, law requires has been sign 2.2 should be npleted		24a. Wa	
of Vital Records,  ng Physician: The law require ther this certificate has been signeral director, page 2 should be 1: To Be Completed		per	formed? death? s 2 No 1 ✓ Yes 2 No
Vital Recipysician: The this certificate of director, page	25. Was case referred to medical examiner? Hospital: 1 Inpution 2 FR/Outs	26.Place of Death (Check only one) patient 3 DOA Other, Nursing Home 5	Residence 6 ✔ Other: Scene
ding Phy	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Tir	1 Voc 2 A No	e how injury occurred onto hit by
Division of tital or Attending ans after dearth. The Director: After in by the function: ertification:	2 Accident Investigation 2/15/09 /:3	a street factory office building etc. 28f Location	Ing traffic
Divis  Divis  Hospital or A  Hours after Finneral Dire tely filled in b	4 Homicide determined (Specify) roadway		State 70 E/B @ Mt. Phillip cederick, MD
To the Howithin 24 H. To the Fin completely	Check only 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.		
Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 16, 2009
I	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21201	

Charles Mc Cray 09-01197 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 10, 2009 0410 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Rear of 1027 Cathedral Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Director 7-05-1950 Country) 219-52-345 Usual Residence of Decedent 10d, Inside City Limits 10c, City, Town or Location 10a, State 10b. County Yes 2 No s 23a or 28a-f show a notified at once. with the Maryland Director 10g. Citizen of What Country 10f Zip Code 10e, Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black S. لل Was Decedent Ever in 11 Marital Status White etc Armed Forces? 1 Never Married Yes Yes 2 No specify: If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after Divorced item 27 is marked other than "natural", traumatic event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 and Mental Hygicne 17. Father's Name (First, Middle, Last) Ch Johnnie mc Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Batto indi West Ridge Rd. Department of Health an Important: If item 27 injury or other trauma 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Removal from State Cremation 3 -09 2-16 Caron Crematore Donation 5 Other Specify: 22. Name and Address of Facility 270 Fred HILTON Pasa Balto. er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and /Medical Death a. Multiple Injuries Immediat Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown ģ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 V Other: Scene Inpatient ER/Outpatient 3 this 1 V Yes ဥ No 28a. Date of Injury (Month, Day Year Feb 10, 2009 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Certification: Subject jumped from building Natural Yes 2 V No Pending

Division of Vital Records, P.O. To the Hospital or Attending Physician: Director: 24 hours after death, To the Funeral

2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

Investigation

Could not be

determined

29c. License number O.C.M.E

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) February 10, 2009

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 1027 Cathedral Street, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D.

Grean

32. Registrar's Signatur

(Specify) Parking Lot

State Registrar

2

Medical

Accident

3 🗸 Suicide

29a. Certifier 1

arke

28e. Place of Injury - At home, farm, street, factory, office building, etc.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7, **Physician** EBRUARY Year 2000 Mott, Jr. Frederick Egbert /Medical 4a. Facility Name (If not ipstitution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Center OWSON Baltimore If Under 1 Year Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day) 1 3 M 2 □ F Months Davs Hours Min Director 125-22-3007 84 1924 June New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in the contract of th 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12261 Roundwood Rd. #1201 21093 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: 3 x Widowed 4 ☐ Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Structural Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick E. Mott Rachel Ethel Dawson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Randall Mott/ Son 11 Cavan Green Nottingham, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 2-18-09 Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 C Ectopic pregnancy Day Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY page 2 should 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 □Yes 2 🛚 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year)
FEB 1 9 2009

29b. Signature and title of certifier

TIMOTHY LOW.

7601 OSLER DRIVE 32. Registrar's Signature parker

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

29c. License number

D24034

TOWSON. MARYLAND

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Рм Marie C. Messina February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center
Social Security Number 6. Sex Parkville Baltimore 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F Months Days Hours Min 98 212-07-8402 Director December 11, 1910 Maryland Usual Residence of Decedent 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits I Hygiene. other than "natural", or items 23a or 28a-f shov rent, the Medical Examiner must be notified at Funeral Director 1 Yes 2 No Maryland | **Baltimore** Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic event, Insulone. Legal Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Francisco Messina Concetta Maggio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Messina, M.D. / Nephew 315 E. Ridgley Road, Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 2-20-09 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary artery Disease **Physician** /Medical Due to (or as a consuluence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Aerti Stenosis Dementra, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 124 hours after death.
 Euneral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2□No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

1 Matural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - CRAP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State FEB19 Registrar

Michealle

8800 Walther Blud, Parkville, MO 21234 32. Registrar's Signatur

Barka

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 11:59 P Charles L. McGuire /Medical Feb. 15, 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 401 Orchard Rd. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Director 235-52-8075 19, 1933 West Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f sho Director 1 □Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21061 401 Orchard Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 □ No 10. Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) heating & air conditioning heating & air condition 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Lennie Tincher Robert Kay McGuire ပ Department of Health and M Important: If Item 27 Is marl any Injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 Mary McGuire / Wife 401 Orchard Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 20 Feb. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville MD Vet. Cem. 2009 Crownsville, Maryland permit. 21. Signal re of Funeral Service License 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 0 421 Crain Hwy. SE; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter this enjoy Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) /sician and certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. been signed by the should be detached 9 Unknown 9 I Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐Yes 2 ZNo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year, 30. and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's Signature State FEB Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 13, 2009 5:26 P **Physician** Rae Louise Mackey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll 3117 Littlestown Pike Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Dec. | 23 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) . Year) 1933 **Funeral** Maine Months 1 □ M 2√√2 F 75 092-26-2581 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Micciest Evolution in at be notified at 1 ☐ Yes 2√2 No Director Carroll Westminster MD 10g. Citizen of What Country? 10e Street and Number death with 21158 3117 Littlestown Pike United States Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, the Muchal Event in 1 Never Married 2 Married 1 ☐Yes 2 🕍No Specify. White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Education Aide Education 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Herbert Allenwood Eva Preston မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3117 Littlestown Pike, Westminster, MD 21158 19a. Informant's Name/Relationship (Type. Print)
Donald M. Mackey - Husband Department of Health ar Important: If item 27 Is any Injury or other trau once. 20b. Place of Disposition (Name of Crestly Company of Chestly Company of Chestles 125 Date 20c. Location - City or Town, State 20a. Method of Disposition
1 Maturial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2-18-2009 Gardens Marriottsville, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. neral Service Lice 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 months ONGESTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a nonsequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FIBRILLATION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier FEBRUARY 16, 2609 120040012

State Registrar

405 FREDERICK ROAD, SUITE DOY, CATONSUILLE, MD 21228 32 Registrar's Signature EB 19 2009 Barker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rougon

31. Date filed (Month, Day, Year)

09 As

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shley Meyers			e of Maryland /				and	Ment	al Hy	giene			_		
		1- For State Registrar 1. Decedent's Name (First, Middle,La		Certi	ificate or	Death			12	Date of Dea	Reg. No.	-20	00	<u>]</u>	195
Physicia ledical Exami		Ashley Nicole Meyer								Month February		Year	ľ	1825 hi	rs
		4a. Facility Name (if not institution, g				4b. City, Tov	n, or L	ocation of		represent		County of D	eath		
		Baltimore Washington M	edical Center			Glen Bu	ırnie	Α.				ne Arun			
Funeral			1 1/	(In yrs. las	t birthday)	If Under	Year Days	If Under Hours	24Hrs.	8. Date of B		I E c	oreign		or or
Director	- 1	220-41-5362	M 2 X F 14		Yrs		Days	Hours	IVIII I.	August	4, 19	94	Coun	itry) MD	
any		Usual Residence of Decedent  10a. State 10b. County	······································	10c. City. T	own or Locat	tion						· -	1	0d. Inside (	City Limits
ž ,,		MD Anne Ar			asadena									1 Yes	2 <b>X</b> No
arylan 8a-f sh at onc	Director	10e. Street and Number				10f. Zip Ci	ode		-		10g. Citizer	n of What (	Countr	y?	
ith the Maryland 23a or 28a-f show notified at once.	Dire	109 Catalfa Avenue					21	122		- 1	USA	A			
with ns 23: be no	ıral	11. Marital Status	12. Was Decedent E	ver in U.S		as Decedent es, specify (					0- 14	4. Race - A		n Indian, B	lack,
death or iter	Funeral	1 X Never Married 2 Marrie	1 Yes 2	X No			-		racitore	ican, etc.)		w	hite	<u>:</u>	
s after ral",	þ	3 Widowed 4 Divorce  15. Decedent's Education (Specify	or Dates:	loted) I	16a. Deceder	Yes 2 X			ind of wo	rk done		pecify: id of Busine	nee/inc	luctry	
2 hours at "natural	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			nost of working					Tob. Kill	iu oi busiiie	;55/HIQ	ustry	
36 thin 72 than edical	ald u	8	0		Stu	dent				•	Edu	ucation	1		
5-0036 The within 72 Hygiene. I other than '	S	17. Father's Name (First, Middle, Las	st)			<del></del>	18			irst, Middle,	Maiden Su	urname)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	William Meyers			T					evenson					
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland that and Mental Hygiene in 77 is marked other than "natural", or items 23a or 28a-f she unmatic event, the Medical Examiner must be notified at once	ဥ	19a. Informant's Name/Relationship William Meyers	(Type, Print ) Eather			<sub>g Address</sub> talfa A						or Iown, S	itate, Z	ip Code)	
두 달 등 등 등		20a. Method of Disposition			ace of Dispos	sition (Name				Date		cation - Cit	y or To	own, State	
ages 1 nt of 1 nt: If i		1 XBurial 2 Cremation 3			ematory or ot 1. Haven	her place)		l,	Feb 18	3, 2009	G1en	Burnie	. M	D	
Baltimore, permit Pages I ar Department of Hee Important: If ite		Donation 5 Other Special     Signature of Funeral Service Lice				Name and Ad	dress o			•					
E P P III		LAY	ONACO		<b>3</b> 20	4 Mount	ain i	Road,	Pasac	lena, Ma	aryland	1 21122	2		
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause on	replications that caused to each line.	he death. E	Do not enter t	he mode of o	lying, s	uch as ca	rdiac or r	espiratory ar	rrest, shock	c, or heart		Approxima Between (	Onset and
xaminer	ij	Immediate Cause (Final disease or condition resulting in death)	a. Head Injuries  Due to (or as a consec					-	_				$\dashv$	De	eath
· Marchane			Due to (or as a consect).	quence or).											
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence of):											
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executed an and al - transit	alEx		d	_							-				
	dica	UNPENDED	AMENDED							_					
68760, certificate be nding physici se as the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	e of pregna	-	etal death	3	Ectopic	nrennan	CV.		Date of del Ionth	ivery Day	v	Year
OX 68760, anth certificate be ex- attending physician or use as the burial	Physician/Medic	past 12 months?	4 Pregnant at ti	ime of deat		ther (Specif)	_	Lotopio	program	-,			50,	,	100
Box e death c the atten ed for us	hys	1 Yes 2 V No 9 Unknow	9 Onknown								1				
cords, P.O. Bo. law requires that the deat has been signed by the at should be detached for	by P	Part II. Other significant conditions	contributing to death	but not res	sulting in the i	underlying ca	ause giv	ven in Par	† I.					e cause of bly 4l	
S, F puires an sign	pe					-			<del></del>	24a. Was				psy finding:	
aw rec	ple			_						auto			r to cor	mpletion of	
tal Rec	Completed									1 🗸 Yes	2No		Yes	2	No
of Vital Records, ing Physician: The law require. The transfer this certificate has been someral director, page 2 should I	Be (	25. Was case referred to medical examiner?	Hospital:		R/Outpatient		To	of Death (			Desides		Nh o m		
f Vit	٤	1 ✓ Yes 2 No 27. Manner of Death		<u>,                                    </u>	at Work?		Home 5 8d. Describe	Residence how injury		Other:					
<b>~</b> ∰ _ ^ ∉	Certification:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea Feb 13, 2009		0000 hrs			es 2 🗸	l R	icyclist i			n a	uto	
Division tal or Attendi rs after death al Director:	licat	2 ✓ Accident Investigat 3 Suicide 6 Could no	28e Place of Inju	ıry - At hon	ne, farm, stre	et, factory, o	ffice bu	ilding, etc. 28f. Location (Street and Number or Rural Route Number, City				mber, City			
Division Hospital or Attence 24 hours after death Fruneral Director: tely filled in by the	er	Suicide 6 Could no determin		or Road	/ Highway	/			R	or Town, itchie Hwy	State) NB @ Ha	mburg St	reet, I	Pasadena	ı, MD
e Hosp 24 ho e Func etely f		29a. Certifier 1 Certifying Physi	cian: To the best of my	knowledge	e, death occu	rred at the ti	ne, date	e and place	ce, and d	ue to the cau	use(s) and	manner as	stated		
To the Hos within 24 h To the Fun completely	Medical		er:On the basis of exam and manner stated.	ination and	or investiga				urred at f	ine time, date					-1
	Σ	29b. Signature and title of certifier	112				.icense D.C.M	number				ate signed Jary 14, 1		h, Day, Year I	7
		Moryone The	Yrule	-al- /11 -	20.0		J.U.IV				I GOIL	, , , , , , , , , , , , , , , , , , ,			
10 1		30. Name and address of person who	o completed cause of de Assistant Medical E			enn Stree	et, Ba	ltimpre.	MD 2	1201					

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-22, perFH, G888, 2/19/09, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 8.35 AM **Physician** -LIAN ANUARY, 31, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday)

| Months | Days | Hours | Min. | Mar 19, Future Care Irvington cial Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Director 214-14-8435 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1√ Yes 2 No Funeral Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22 S. Athol Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🎇 No Specify: Specify: black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Future CAre Irvington 22 S. Athol Avenue Baltimore, MD Department of Health Important: If item 27 any injury or other trong. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ■ Cremation (Specify) - in state CEMETERY 2-18-2009 BALTI 2 Name and Address of Facility Phillips F/H 21t Name of Except Strain Str MT. ZION CEMETERY BALTIMORE, MARYLAND 21. Signature of Euneral Service Licer Wad Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMERS STAGE **Physician** END DMENTIF TWO YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of r. the burial-tran and Due to (or as a consequence of) physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown INFECTED DECURITI 24b. Were autopsy findings available prior to completion of cause of death? DIAK 24a. Was an autopsy page ; ESSENTIAL TENS ION FAILURE TO THRIVE 1 DYes 200 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed of Vital Records, certificate or Attending Physician: this After thi funeral Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

Baltimore, Maryland 21215-0036

Box 68760

P.O.

permit.

State Registrar

31. Date filed (Month, Day, Year) FEB19

3455, Wilkens Ave, Ste LIO, BALTIMORE, MD 2/229 K. DANG M.D. 32. Registrar's Signature

Ceray

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

D0018362

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend #8, 20a-State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4:50 PM Frederick H. Nevils February 2, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7262 Donnell Place Forestville Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. Noving Manth, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☑ M 2 ☐ F 578-58-1053 65 Director Jan 25, 1944 Washington DC Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County show 10a. State 1 □Yes 2□ No Item 27 is marked other than "natural", or Items 23a or 28a-f st other traumatic event, the Medical Examinar must be notified Director MD Prince George's Forestville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 7262 Donnell Place USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H Be Frederick Nevils Pearl Green 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4084 Adams Court Silver Spring, MD Queen Nevils/sister in law 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. rem. Cemetery 2/28/2009 Suitland, MD
22. Name and Address of Fa jity Hodge 6 Fdv d. F.H. 3010 Silver Burial 2 Cremation 3 Removal from State in state Lincoln Mem. Cemetery 2/28/2009 4 □ Donation → ₩ Oth Funeral Se, ice Licensee erret Hill Md irector 21201 Suitland, MD 20746 inn 23a. Part 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sinck, or heart failure. List only one cause on each line. Immediate Couse (Final HyperTer Arteriosclerot **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a ☐Yes 2☐No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Vital Physiclan: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ■ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H8033927 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person & Drive, Chever

State Registrar (VANO

31. Date filed (Month, Day,

Year)

Hos

Begistrar's Signature

			For State Registrar		State o	f Marylar		ertment of F		Mental Hy	/giene	009	04953
			1. Decedent's Nam	ne (First, Middle	Last)					2. Date of De	eath		3. Time of Death
	Physic /Medi		Martha J							Month Febru	ary 17	Year 7 2009	7:54 A M
	Examii				give street and nur	mber)			or Location of Death	1	4c. Co	ounty of Death	
	Funeral	-	199 Roll 5. Social Security N		nue 6. Sex	7. Age (In yrs.	. last birthday	Rockvi		8. Date of Bi		ntgomer	lace (State or Foreign
	Director		212-74-5	8883	1 □ M 2 🔀 F	84	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Cour	ington DC
	and w		Usual Residence o	f Decedent 10b. County		10c C	ity, Town or L	ocation					0d. Inside City Limits
	Maryli -f sho	tor	MD	Montg	omery		Rockvi						1 √2 Yes 2 □ No
	h the	irec	10e. Street and Nu	mber				10f. Zip Code			10g. Citize	n of What Cour	itry?
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	items	nue	11. Marital Status 1 ☐ Never Marr	ind O Marris	Armed Fo	edent Ever in Urces?	J.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerte	pecify Yes or No Rican, etc.)	0- 14.	. Race - Americ Black, White, e	
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<b>d</b> 2	Hygi other ent, I	Be Co	17. Father's Name		ast)		lincer	nal Reven	18. Mother's Nam				ernment
/lan	uld be Menta arked	10 B	John W.	Miller					Pearl Ke	esmodel			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine Injust be notified at once.		19a. Informant's Na E.N. Fau	ame/Relationsh 1kner/D	p (Type. Print) aughter		19b. Mail 2880	ing Address (Street Florence	and Number or Ru Road, Wo	ral Route Numb Oodbine	er, City or To • MD	own, State, Zip 21797	Code)
ore	ges 1 at of He If item or oth	1 8	20a. Method of Dis		B □ Removal from S	State	cemetery, cre	osition (Name of matory or other plac	ce) ¦	Date	20c. Locat	tion - City or To	wn, State
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Divis	tal or Att rs after de al Direct ed in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6	28e. Place of building	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str fy)	eet, factory, office		28f. Location (5 City or Tox	Street and No vn, State)	umber or Rural	Route Number,
Nichally Div	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1X Certifying 2☐ Medical E	Physician: To the caminer: On the ba	isis of examina	wledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as stace, and due to	ated. the cause(s)
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1	<b>∤</b>		30. Name and addre		oseph, 50				Ste.207.	Rockvi	lle. M	ID 2085	52
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	Registr	ar		FEB19	2009	com	A. A	arkel					

State of Maryland / Department of Health and Mental Hygiene 04954 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 13, Russell Lee Niner 2009 Ам 9:16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center For Hospice Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 6, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 58 213 64 8271 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Expressionar burst be profifted at 10d. Inside City Limits Baltimore Director Maryland Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 North Marlyn Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite 1 Mayes 2 □ No
If Yes, Give 1970/76
Year or Dates: 1970/76 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛛 No Specify ੬ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service 12 Clerk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Richard Niner Dolores Cecilia Nolan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Ann Niner (Daughter) 229 North Marlyn Avenue Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens: 2/16/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. 1 t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EMBOUSM ULMON AREY /Medical Due to (or as a consequent of): **Examiner** METASTATIC TRANSITIONAL CELL CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be en thin 24 hours after death. This is a hours after death. The transmission of the strength of the strengt Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed VASCULAR DISTARS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2000 2 □ No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify) HOSP(CE 1□Yes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 MNatural 2 Maccident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 FEBRUARY 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0+1 BALTIMORE, MO 21204 6565 N CHARLES ST, SUITE 209 DOBERMAN, MO DANIEUE 82. Registrar's Signature 31. Date filed (Month, Day, Year) 9 2009 Registrar

3altimore, Maryland 21215-0036

Records, P.O. Box 68760.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician lewsome Wia 7:41PM 2009 6 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore arkville Edgewood Koad Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 19.86.5068 Days 1 □ M 2 🗡 F Months Hours Min Yrs Director 03 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "Accidal Examinar is usites notified at MD Battimore Parkville 1 ☐ Yes 2 X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1809 Edgewood USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ≥ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within College (1-4or 5+) is marked other than Elementary/Secondary (0-12) Senior Benefits Analyst Insurance 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephus Willis, >r. endora White ပို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. Rosedale MD 21237 xster TOWNSEL 22 Chriswell Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD 02 24 09 4 ☐ Donation 5 ☐ Other (Specify) Vaugho C. Greene Fundral SICS 21. Signature of Funeral Service Licensee Vaux C. ye iberty Road Randall stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Physician micer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2★♥No 24a. Was an cate has page 2 s autopsy this certificate 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 6 ☐ Other (Specify) After thi funeral of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) DIRECTOR, D23675 sellan - MEDICAL ONCOLOGY

DHMH 17 Rev 1/2001

State

Registrar

Johns Hopins Course Conter

Beltruone, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

ROSS C. DONEHOWER, MID

Year)

FEB 1

31. Date filed (Month, Day,

			For State Registrar	State of Maryland	-	artment of F rtificate of			_	_	2009	9 049	958
	Physici	an	Decedent's Name (First, Middle, Las.     SHIRLEY		EEDLE		-		Date of Dea	ath		3. Time of Do	eath
· V	/Medio		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o		of Death	<u> </u>		County of Dea	th	
	Funeral Director		218-22-0589		ast birthday) Yrs.	DE I If Under 1 Year Months Days	RWOOD If Under Hours		Date of Birt (Month, Da	) 1922	9. Bir	thplace (State or Fountry)	Foreign
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City	
	he Mar 28a-f sl	Director	MD BALTI  10e. Street and Number	MORE		BALTIMORI	Ε		<del></del>	10a Citi	zen of What Co	1 ☐ Yes 2	No
	th with t	al Dir	7 SLADE AVENUE	, #408		2120	08			_	USA	ontry :	
5-0036	be filed within 72 hours after death with the Maryland nal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evana har mat be metited at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates:		Was Decedent of H fYes, specify Cuba I∐Yes 2 No	lispanic Or an, Mexica <i>Sp</i> ec <i>ify</i>		y Yes or No- can, etc.)		14. Race - Ame Black, White Specify: W		
1215-0	within 72 ho iene. • than "natur he Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) 5+	(Give life. L	tent's Usual Occup kind of work done OO NOT use retired TEACHER	ation during mos d)	st of working			nd of Business/		
Maryland 2121	should be filed and Mental Hygi marked other imatic event,	Be	17. Father's Name (First, Middle, Last)					er's Name (F	irst, Middle,	Maiden .		TAL	
aryla	should be I and Mental s marked o	P P	SAMUEL 19a. Informant's Name/Relationship (	APPLEFELD Type. Print)	19b. Mailin	g Address (Street		ERESA per or Rural F	loute Numbe	er, City or	LEV r Town, State, 2		
ë,	s 1 and 2 should of Health and Men item 27 is marke other traumatic		ELLEN BERMAN / D			CHEVY CHA	ASE R	D #101			SBURG,		8
Baltimore,			20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Denation 5 ☐ Other (Specify	Removal from State ANS	metery cien	NAH MCONG.	ce)	02/18/			LTIMORE		
Balt	permit. Page Department Important: If any Injury or once.		21. ignature of Funeral Service Lice		22	Name and Addre					& BROS ESVILLE		:08
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only	one cause on each line.	. Do not ente							Approximate Interval Between	en
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ								MONTHS	
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	xecuted and II-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
09/89	ificate be executed g physician and is the burial-transit	edical E		,d			· · · · · ·						
O. Box 6	death certi ne attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛱 No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnanc	у			2	23d. Date of del Month	ivery Day Yea	ar
J.	law requires that the de as been signed by the 2 should be detached	ğ	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the un	derlying cause giv	en in Part I	l.				the cause of dea	
Vital Records,	The lay ate has bage 2	Completed								sy med? 2 🔼 No	prior to death?	topsy findings ava completion of caus 2 □ No	ailable se of
	dies 🔏	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA Oth		e of Death <i>(C</i> ursing Home			i <b>X</b> IOther <i>(Spe</i> i	cify) HOSPI	CE
o uo	Attending Physician: If death. ector: After this certificing by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c, İnjur Worl	y at k? Yes 2 □	28d	l. Describe h				
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre )	eet, factory, office		28f.	Location (S City or Town	treet and n, State)	d Number or Ru	ıral Route Numbei	r,
	e Hospit 24 hour e Funera letely fills	edical (	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tire restigation, in my o	me, date a pinion, dea	nd place, and ath occurred	d due to the o at the time, o	cause(s) late and	and manner as place, and due	stated. to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier  JECELYNE &	DUATCHOU	, m/	29c. Licens		7118	2		e signed (Month		
			30. Name and address of person who	completed cause of death (Item	23a) (Type, F	Print)			)OD :::		/17/200	J	
)	Sta	te	JOCELYNE KOUATC 31. Date filed (Month, Day, Year)	32 Reflictrar's Signatu	Iro	TER MILL	ки.,	DEKWU	, MI	J 2	0855		
	Registr		FER 192	009 Densum	1. 1	arked							

DHMH 17 Rev 1/2001

			State of Maryland / Department State of Maryland / Department Certificate	t of Health and M e of Death	lental Hygien	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month February	3. Time of Death <b>2009 5:42</b> p M
-	/Medic	al	Constance Louvinia Peregoy  4a. Facility Name (If not institution, give street and number)  4b. City,	Town, or Location of Death		2009 5:42 p M
	Examin		Laurel Regional Hospital Lau	ırel	P	rince George's
	Funeral Director		5. Social Security Number  214-20-6652    6. Sex   1 □ M 2	Days Hours Min.	8. Date of Birth (Month, Day, Yea DEC 10 192	9. Birthplace (State or Foreign Country) West Virginia
	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar	Director	MD Prince George's Laurel			1 □Yes 2X No
	th with th	al Dire	9010 Briarcroft Lane, Apt. 325	0 <b>70</b> 8	10g. C	Citizen of What Country? USA
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  1 □ Newer Married  2 □ Married  1 □ Yes, Give Year or Dates:  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ♠ No If Yes, Give Year or Dates:	dent of Hispanic Origin? (Spe cify Cuban, Mexican, Puerto 2 <b>X</b> No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
2-0	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of wo	al Occupation rk done during most of working se retired)	16b.	Kind of Business/Industry
21215-0036	within iene. than	Completed	Elementary (Secondary (0-12) College (1-4or 5+)  Homemaker			Own Home
land 2	ild be filed lental Hyg ked other kc event, l	e l	17. Father's Name (First, Middle, Last)  Jack Robey	18. Mother's Name	(First, Middle, Maide t Howell	
Maryland	nd 2 shou lith and N 27 Is mar r traumat		19a. Informant's Name/Relationship (Type. Print) Willard W. Wolf - nephew  19b. Mailing Address 58 Wade A	(Street and Number or Rura venue, Catons	al Route Number, City ville, MD	or Town, State, Zip Code) 21228
Baltimore,	ages 1 ar ant of Hea ant if Item ; y or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Nacemetery, crematory or complete to the complete of the compl			Location - City or Town, State
<b>3altin</b>	ermit. P epartme nportan ny Injuri nce.		21. Signature of Funeral Sergrevent H. Williams 22. Name a	ation Society	of Maryla	and, Inc.
	<b>0</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the more	Frederick Roa	d, Baltimo	ore, MD 21228  Approximate
,	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	. •		Interval Between Onset and Death  1 week
	/Medical		disease or condition resulting in death)  a. Respiratory Fail Due to (or as a consequence of):  Decompensated CF			
	Examiner	Į.		··-		l week
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
, 0,	Atlanding Physician: The law requires that the death certificate be executed redeath.  rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	І Еха	Due to (or as a consequence of):			
68760,	ficate I physic s the b	edica	d			
Box (	eath certific attending p for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 permits?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic	areanancy.		23d. Date of delivery
O. B	ie deat the att hed for	Physician/Medical	in the past 12 menths?  1   Yes 2   No 9   Unknown 9   Unknown			Month Day Year
<u>o.</u>	uires that the de		Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	w requires been sign should be	ed by	Chronic Lymphocytic Leukemia		1 ☐ Yes	2 No 3 Probably 4 ☑ Unknown
oce	law re nas bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>=</u>	siclan: The certificate h irector, page				performed/? 1 □ Yes 2 1 1	
of Vital Records,	ysiclaris certi	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	26. Place of Death		6 ☐ Other (Specify)
n of	ding Phys h. After this funeral di	n: T			28d. Describe how inj	
sioi	tendir leath. tor: Al the fu	catic	2 Accident investigation M	1 ☐ Yes 2 ☐ No	001	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	/, oπice	City or Town, Sta	and Number or Rural Route Number, te)
	e Hospi 24 hou e Funer letely fil	Medical	29a. Certifier  (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred control of the basis of examination and/or investigation and manner stated.			
	To the within To the comp	Me	29b. Signature and title of certifier 29	c. License number	29d. D	Date signed (Month, Day, Year)
			) / V · ( C · N	D66515		02/17/2009,
l	IV		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Nishi Rawat, MD, 10724 Little Patu	ıxent Pkwv	. Suite :	21044 200. Columbia. MD
	Sta	ite	31. Date filed (Month, Day, Year) 32. Degistrar's Signature		, 22200 4	, coramora, no
	Registr	ar	FER 19 2009 June S. park			
	/IH 17 Rev 1/2	001				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death <sup>D</sup>19 2009 Month February **Physician** 2:10 a Lois Ann Perry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 611 Highvilla Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | AUG 10 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2X F 63 218-42-5892 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Exansism rust be natified at 1 ☐ Yes 2 X No MD Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21221 611 Highvilla Road Funeral 2 should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Hair Stylist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ford Ida Cosmo Cappadocia ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 611 Highvilla Road, Essex, MD Item 27 i Gerald Perry - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 / 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/19/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Heeffee H. Williams <sup>22</sup>Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BLADDEN AUCEN **Physician** 4 yrans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician at the burial O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 ☐ Yes 2 D No certificate 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō

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seral Director: A
filled in by the fu To the Hospital within 24 hours a To the Funeral L

29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

lation

29c. License number D78768

2/20/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650 NONCEANS ST IN SI BALTITURE MD 21237-1000 MANIO A. FIRGINBRUGEL #10

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



09-01168 Please Type or nt in Black Indelible Ink. Ensure All Come Are Legible. State of anaryland / Department of Health and Mental **UNK UNK** 009 04959 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Eric Alonzo Pendergrass, 2. Date of Death Physician/ Month Day February 9, 2009 0742 hrs **Medical Examiner** ENDE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 200 Block of West Patapsco Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Country) MARYLAND 218-48-6735 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 2 10a. State 10b. County BALTIMORE 1 X Yes 2 No 28a-f show NIA MARYLAND must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 1.5.F. 2121 AVENUE AVONDALE 3405 238 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 11. Marital Status or items White, etc. Armed Forces? 1 X Never Married death Yes If Yes, Give Year Specify: BLALK imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or other traumafic event, the Medical Examines. 1 Yes 2 No specify: 3 Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EMPLOYED SELF 2TH GRADE 50BS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last PENINERIARISS SR. ALONZO RENEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 34D5 AVONDALE AVE., CALTIMORE, MD 21215 (MOTHER) 311174 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth 02/20/201 MEMORIAL PARK Donation 5 Other Specify permit. 22. Name and Address of Facility 50 SEPH H. BROWN SR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21215 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Asphyxia Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit the Hospital or Attending Physician: The law requires that the death certificate be executed X AMENDED #1, perME, g888 2/26/09 vsician/Medical UNPENDED signed by the attending physician be detached for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Р</u> ۵ Part II. Other significant conditions ģ 1 Yes 2 ✔ No 3 Probably 4 Completed Division of Vital Records, funeral director, page 2 should 24a, Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medica Be Hospital: 1 examiner? Other: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 2 1 Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death Subject assaulted Certification FOUND: Natural Yes 2 V No Pending hours after death. To the Funeral Director: 0700 hrs Feb 9, 2009 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 200 Block of West Patapsco Avenue, Baltimore, MD determined (Specify) River 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 10, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Yea State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

Gic Pendergrass

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09-01104 Sheldon Ray Parri		S	pe or Print i	and / Depa	artment o	f Health ar		ies Are Le iene	egible		
	_ JF	- For State Registrar		Cei	rtificate o	f Death			Reg. No.	200	
Physician Medical Examine	er	1. Decedent's Name (First, Mid Sheldon Ray 1	Parrish					2. Date of De Month February	6, 200		3. Time of Death 1558 hrs
)	•	4a. Facility Name (if not institut Good Samaritan Hos		umber)		4b. City, Town, o Baltimore	r Location of Dea	ath	40.	. County of Death	
Funeral Director		5. Social Security Number unk	6. Sex	7. Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under 1 Years.  Months Day		8. Date of E lin. 11/06		Foreig	thplace (State or on ountry) Maryland
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ow any	1	10a. State 10b. County	/	1 7	ltimore						10d. Inside City Limits  1 X Yes 2 No
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he Ma	Director	1543 Puttyhi	ll Road			2123	7			S.A.	
with 1 with 1 so 23s be not		11. Marital Status	12. Was De	cedent Ever in U		as Decedent of H	ispanic Origin? (			14. Race - Ameri	ican Indian, Black,
T SCCC	<u> </u>	1 Never Married 2 X	1 Yes	2 X No	IT \	Yes, specify Cuba	in, Mexican, Puer	rto Rican, etc.)		White, etc.	
hours after "natural", Examiner	줍-		ivorced If Yes, Give Ye or Dates:			Yes 2 X No		of work done		Specify: Whi	
2 hour "natu	Eg -	15. Decedent's Education (Sp Elementary/Secondary (0-12		(1-4 or 5+)		nt's Usual Occupa nost of working life			16D. K	and of Business/	Industry
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5-00 Hygier offher	3	17. Father's Name (First, Middle	e, Last)				18.Mother's Nar	me (First, Middle	, Maiden	Surname)	
	a B	Walton Parris 19a. Informant's Name/Relation			405 14-33	- Address (0)	unknow				
MD 2 d 2 shoul lith and N n 27 is m aumatic	2	Wilma Lee Pai			4	ng Address (Stre Hamilton					
e, N I and 2 Health item 2	1	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of ce		Date		Location - City or	
more, Pages 1 and orte of Healt of Healt of Healt or other trains or other trains	1	1 Burial 2 Crematic		II OIII State	crematory or o	<sub>ther place)</sub> ts Registr	v   02	/19/200	о на	nover, N	Maryland
Baltimore, permit Pages I an Department of Hea Important: If ite		21. Signature of Funeral Service				Name and Addres		natomy	Gift	s Regist	ry
<b>0</b> 20 11	, l	5015			75	522 Conne	elley Dr	rive, St	e.P,	Hanover	MD 21076
Physician /Medical xaminer		23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseasor condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus.	te on each line.  se a. Narco  Due to (or as  b. Due to (or as	otic (Mog a consequence of	rphine n and c	oxycodo	one) & d				Approximate Interval Between Onset and Death
T ted	al Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o							
× :	g	X UNPENDED	AMENDED	23a,27,	28a-f,	perME, g	3888 2/2	3/09 TT			
	2 2 2	F FEMALE: 3b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U	the 1 Live 4 Preg	, outcome of preg birth nant at time of de nown	2 F	etal death 3 ther (Specify)	Ectopic preg				Day Year
P.O. res that the signed by be detach	[[6	Part II. Other significant cond	litions contributing	to death but not r	esulting in the	underlying cause	given in Part I.		_		the cause of death?
of Vital Records, P.O. B is Physician: The law requires that the d ther this certificate has been signed by the meral director, page 2 should be detached as To Be Commissioned by Day	Completed							perl	s an opsy form <u>ed?</u> 2 ✔ N	prior to death?	utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	or F	25. Was case referred to medic	al			26.Plac	e of Death (Chec			<u> </u>	2 10
of Vital Recing Physician: The After this certificate uneral director, page	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸	ER/Outpatien	t 3 DOA	Other Nurs	sing Home 5	Reside	nce 6 Othe	r:
n of \ ding Ph. L. After tl funeral	. [2	27. Manner of Death  1 Natural 5 Death	(Mont	e of Injury th, Day,Year)	28b. Time of	· · · I ·	ury at Work?	28d. Describe	e how inju	iry occurred	
Division or Attending spiral or Attending sours after death. Heral Director: Al fillled in by the fun		2 Accident Inv	conganon	2/6/09 ce of Injury - At h	Fd 3:2	1 pm —	Yes 2X No	unk	/Stroot n	nd Number of Di	ıral Route Number, City
Divi		3 Suicide 6 X Code det	uld not be Specify		ome, iaim, stre	et, factory, office	bulluling, etc.	or Town,	State) ]	1543 Put	ty Hill Rd
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the I	- 1	29a. Certifier (Check only 1 Certifying I	Physician: To the becaminer: On the basis	est of my knowled of examination a				nd due to the car	use(s) an	d manner as stat	ed.
To with	ĕ	29b. Signature and title of certif	and manner fier	stated.		29c. Licen	se number		29d. [	Date signed (Mo.	nth, Day, Year)
		(me IZ				O.C	.M.E.		Feb	ruary 7, 2009	9
0 1		30. Name and address of personal Ana Rubio MD. As	on who completed cau			Street, Baltim	ore. MD 212	01			
⊗ Stat	te 3		32.	egistrar's Signatu	Iroff #				-		
Registra	ar	31. Date filed (Month, Day, Year FEB19	2009	enema ,	O. pa	Med					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 14 Year 2009 Day **Physician** 7:30 PM Marland Quinland Passini Sprua /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Baltimore Seasons Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 31, 1928 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 81 Director 041-22-3568 Connecticut Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural"; or Items 23a or 28a-f show other traumatic event, the Wedical Examinar must be notified at Director 1 √ Yes 2 No Baltimore City Maryland 10e. Street and Number 10g. Citizen of What Country? 21211 U.S.A. 3363 Falls Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank R. Passini Sophia E. Rood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3361 Falls Road, Baltimore, Maryland Mike Hellman / Neighbor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fair View Cemetery Unknown Winsted, Connecticut 21. Signatur Funeral Service Liceuse 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** /Medical Due to (or as a consequence of): Examiner Lung Mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami the attending physician and thed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown paga 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 2 NO 1 ☐ Yes 2 ₩ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funaral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

21 State
Registrar

State 31. Date filed (Month, Day,

32. Registrar's Signature

2835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

back

Baltimore MD

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical SSON 17-2009 ity Name (If not institution, give street and number, Examiner 4b. City, Town, or ocation of Death 4c. County of Death Social Security Number **Funeral** 8. Date of Birth 9 Birthplace (State or Foreign Country) Mary Land 212-58-2257 1 1 M 2 □ F Months Davs Hours Min Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Pikesville Director 1 ☐ Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 3226 Marnat Rd. 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 ☑No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Instance Jones. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter self employed 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Presson Isabel McDonald ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Marnat Rd. Pikesvillemd. 21208 Margaret Presson - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. Feb. 20,2009 Pikesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel F. . . Hand Elhal 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 4 hours /Medical Due to (or as a nsequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been s funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ₩ ο 24a. Was an autopsy performed' 1 Ses 2 □ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No pital: 1 Annpatient 2 28a. Date of Injury (Month, Day, Year) After this Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 1 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) To the ! and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause 301 S. Poul Place. 1esci

Registrar DHMH IV Rev Magor

State

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's

Registrar
DHMH 17 Rev 1/2001

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Charles

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32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanc

Year)

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			For State	State	of Marylan	d / Depa	artment of H	lealth a	nd Mental	Hygien	e2009	04964
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- Salahari			Future Care 5. Social Security Number	6. Sex	7. Age (In yrs.		Balto If Under 1 Year		4 Hrs.   8 Date	of Rirth	N/A	place (State or Foreign
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			Usual Residence of Decedent								. 72 -	VA
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	a-fs	턍	MD	N/A	Ва	ltimo	re					1 MaYes 2 □ No
	or 28	Director	10e. Street and Number		•		10f. Zip Code		-	10g. C	itizen of What Cour	ntry?
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	tems	Funeral	11. Marital Status	12. Was Ded Armed F	edent Ever in U. prces?	S. 13, \	Was Decedent of H f Yes, specify Cuba	ispanic Orlgi In, Mexican,	in? (Specify Yes Puerto Rican, et	or No-	14. Race - Americ Black, White,	
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<u>a</u>		To B	William Sell	.s				Blan	che Ma	rshal	1	
Maryland	should than and Men s marker to marker to marker	_	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailin	g Address (Street a				or Town, State, Zip	Code)
	and 2		Phyllis Reed	l-Daught	er	110	3 Bonapa	arte	Avenue	Balt	o, MD	
altimore,	of He		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of	e)	Date	20c. L	ocation - City or To	wn, State
Ĕ	Page ment ant: I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State Wo	odľaw	n Cemét	éry 2	-21-20	09 Ba	lto Co,	MD
ä	permit. Pages 1 and 2 should b Department of Health and Ment Important: If Item 27 is marked any injury or other traumatic e once.		21. Signature of Foreral Service	icensee		22	. Name and Addres					
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death each line.	h. Do not ente	er the mode of dyin	g, such as ca	ardiac or respira	tory arrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	_ a	Rana	1 Fa	uline					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):						
	Examiner	L	Sequentially list conditions.	b	The state of the s	enr						
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XOR	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						23d. Date of delive	erv
ň	Attending Physician: The law requires that the death redam regard.  redam: After this certificate has been signed by the atter ector: After this certificate has been signed by the funeral director, page 2 should be detached for up the funeral director.	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Preg	birth 2 Petal nant at time of d		Ectopic pregnancy Other (specify)	·		_	Month	Day Year
5	t the by th ache	hys	9 🗆 Unknown	9 ☐ Unki	nown							
ທົ	ss tha gned se del		Part II. Other significant condition	ns contributing to d	-	-		n in Part I.	23e.	Did tobacco	use contribute to th	ne cause of death?
2	en si	ed	Degenint	a Jon	F 11	sear	<u> </u>		_ (	1 ☐ Yes 2	☐ No 3☐ Prob	oably 4 Tunknown
Hecords,	e law re has be	Completed by							24a.	Was an	24b. Were auto	psy findings available
Ĭ	The late has bage	E O							_	autopsy performed? Yes 2⊞No	death?	mpletion of cause of
VITAI	sian: ertifica	BeC	25. Was case referred to medical					26. Place of	f Death (Check		10163	2 🗆 110
>	hysic his ce I direc	2	examiner? 1 ☐ Yes 2 ☐ Ho	Hospital: 1 🗆	Inpatient 2	ER/Outpatient	t 3 □ DOA Othe	r: 4 🗆 Hurs	ing Home 5	Residence	6 ☐Other (Specify	(v)
0	ng Pl	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury th, Day, Year)	28b. Time of Injury	28c, Injury Work	at at		cribe how inju		
0	endi eath. or: A the fu	Sati	2 ☐ Accident investig	ation				res 2□No	)			
DIVISION OT	r Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e, Place	of Injury - At ho ng, etc. (Specify	me, farm, stre	et, factory, office		28f. Local City of	tion (Street ar	nd Number or Rura e)	I Route Number,
ב	urs al urs al ral D											
	Hosp 24 ho Fund stely f	lica	29a. Certifier 1 ertifyin (Check only one) 2 Medical I	g Physician: To the Examiner: On the b	iasis of examina	wledge, death tion and/or inv	occurred at the time estigation, in my of	ne, date and pinion, death	place, and due to occurred at the	to the cause(s time, date an	s) and manner as s d place, and due to	tated. the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical	29b. Signature and title of certifier	and man	ner stated.		29c. License				ite signed (Month, i	
	F≯Fŏ			<b>/</b>	The state of the s	m		1464	1		119/09	
,		Ì	30. Name and address of person	who completed cour	se of death (Item	23a) (Type F	Print)		1			
/	5 V			ASHM(	, 821	N.E	NTAW S	ST fr	ute 30	8 BA	HLTIMOR	ZE M1) 21 0
	Stat	te	31. Date filed (Mibhth," Day, Year)	32. F	tegistrar's Signat							
	Registra	ar	FEB 1 9 20	09 Area	m B.	frank						
						- 07						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 16, 2009 Zena Robinson 5:10 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2/5/F 216-03-6615 98 08/06/1910 South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Avenue, Apt. 216 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Sales Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Jacobs Rosie Haire 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wagner (Grandson) 123 Habersham Drive, Longwood, Florida 32779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 02/20/2009 Elkridge, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Sarvice Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Expert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi e Cause (Final disea or condition resulting in death) ec onge on we Due to (or as a con enuence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical Examiner Examiner

**Physician** 

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show

is marked other

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event,

Funeral

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Completed

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

and burial the attending physician hed for use as the buria signed by has been page 2

Physician/Medical

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Completed

Be

Certification: To

Medical

Box 68760.

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Division of Vital Records,

To the Hospital or Attending Physiclan:

the death certificate be

this certificate After thi funeral within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certified

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOL Thin

1124 Marce Due Batto, MD

State Registrar 31. Date filed (Month, Day, Year) FEB 9 2009 32. Registrar's Signature

and manner stated

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

Heinz

Hans

4a. Facility Name (If not institution, give street and number)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death

4b. City. Town, or Location of Death

Rea. No.

Day

14, 2009

4c. County of Death

3. Time of Death

1:58 PM

2. Date of Death

February,

DHMH 17 Rev 1/2001

Registrar

			For State	State of Maryland / D	Department of Healt  Certificate of Dea		2000	01000
	=		Registrar  1. Decedent's Name (First, Middle, Last		Certificate of Dea	2. Date of De	Reg. No. 2 U U J	04968
П	Physic		Dorothy Ric	,		Month	Day Year	3. Time of Death
-	/Medi Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Locat		5 , 2009 4c. County of Death	9:30A <sup>™</sup>
-			Future Care/ Cl	narles Village	Baltimor	е	N/A	
	Funeral	Funeral Director	5. Social Security Number 6. Se		Months Days Hou	nder 24 Hrs. 8. Date of Bir urs Min. (Month, Da	rth 9. Birth	place (State or Foreign ntry)
	Director		133-18-7340 Usual Residence of Decedent	93	Yrs.	July		A
	yland 10w		10a. State 10b. County	10c. City, Town	or Location	-	1	10d. Inside City Limits
	e Mar		Maryland N/A	Balti	more			ty∑Yes 2∐No
	or 28	Dire	10e. Street and Number 1520 W. North A	venue Ant 510	10f. Zip Code		10g. Citizen of What Cour	ntry?
	s 23a	eral						
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show final Examination with	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex  1 □ Yes 2 No Spe		14. Race - Americ Black, White, Specify:	etc.
5	72 h	Completed	15. Decedent's Edu (Specify only highest grad	location 16a.	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Business/In	dustry
121	within ene. <b>than</b>	James 1	Elementary/Secondary (0-12)	College (1-4or 5+)	omemaker		Own Home	
Baltimore, Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, its Marcal Event permitted any higher.	Be Co	10th grade 17. Father's Name (First, Middle, Last)	пс		lother's Name (First, Middle,	L	
		To B	Joseph Richards	son		Georgie Wi	,	
			19a. Informant's Name/Relationship (7) Ronnie Brown/	rpe. Print) 19b. God Son 222	Mailing Address (Street and Nu 24 W. Saratoga	umber or Rural Route Numba St. Balti	er, City or Town, State Zin More, Md 21	, <u>Code</u> ) 223
			20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State 20b. Place of cemeter Arbuti	•	Park 2720/09		
			21. Signature of Funeral Service Licens	Harris	22. Name and Address of Fa	rstown Rd E	Baltimore, M	eral Home Ad 21215
	by Cornes as the burial-transit attending physician and for use as the burial-transit attending to the burial-transit attendin		23a. Part 1. Enter the disease, o compleshock, or leart failure. List only of Immediate Cause (Final disease or condition	ications that caused the death. Do not not cause on each line.	not enter the mode of dying, such	h as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
			resulting in death)	Due to (or as a consequence of	of):			
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o. Atter Seles h	i Cazdin Nozu	for disease	re	
		xan	that initiated events resulting in death) Last	Due to (or as a consequence o	of):			
68760,	siciar siciar buri	cal	L,	4				
	tificat ng phy as the	ledical		d-				
Division	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
	that ned by deta		Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Pa	art I. 23e. Did to	obacco use contribute to th	ne cause of death?
	v requires been sig should be					1 🗆	Yes 2 No 3 Prob	ably 4 🗊 Unknown
	e law requ has been re 2 should	Completed				24a. Was		psy findings available
	Physician: The this certificate had director, page	Com				autop perfo 1 □ Yes	rmed?// death?	mpletion of cause of
		Be (	25. Was case referred to medical examiner?			lace of Death (Check only o		
	Physi this o	To.	T les 2 WINO	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)				
	ling After fune	Medical Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. T	ime of 28c. Injury at jury M 1 ☐ Yes 2		now injury occurred	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, far			Street and Number or Rura	l Route Number
			4 ☐ Homicide determined	building, etc. (Specify)		m, State)	,	
			29a. Certifier (Check only one)  1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	To the within 2 To the comple		29b. Signature and title of certifier	10	29c. License numb	3 7	29d. Date signed (Month, 1 2 - 17-09	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PARSHAN_S, SALYMAD 1600 W. MOUNT RIGAL A							MJ 212	(7
	Sta Registr		31. Date filed_(Month, Day, Year)	82. Registrar's Signature				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARY RADTKE

4a. Facility Name (In Ort institution, give street and number)

Kris Leigh Assisted Living **Physician** ebrua /Medical County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Severna Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug • 16, 1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 219-38-9560 1□ M 2▼ F 88 Mary Land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it a Medical Examinar must be notified at 10a. State 10c City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Expuringer must be notified at MD Baltimore 1 ☐ Yes 2 No Arbutus Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5509 Sycamore Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 White Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Volunteer Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer C. Newton Blanch Dickerson ပ္ 19a. Informant's Name/Relationship (Type. Print)
Steven Moxley - Personal Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. 33 Musket Court, Taneytown, MD 21787 20b. Place of Disposition (Name of Mean of 120) 20a. Method of Disposition
1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 2-16-2009 Elkridge, MD Park Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has e 2 s 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 6 Other (Specify 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No reral Director: / 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. within 2. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Y30 B MD 32. Registrar's Signature onth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician  $02^{-1}6-2009$ 4:00 p.M O'neal Reynolds Rickey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Takoma Park If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day) **Funeral** Months Days Hours 1 XM 2 ☐ F 01-13-1971 Washington, DC **Director** 214-08-6494 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examinar must be notified at Director MD Seat Pleasant Yes 2 No PG 10f. Zip Code 10e Street and Number 10g Citizen of What Country? 702 66th Ave. 20743 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Spec Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed of Health and Mental Hygiene, item 27 is marked other than "natur other traumatic event, in Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Linen Transportation 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tiny M. Houston Reynolds Rogers L. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1330 Hemlock St., NW Washington, DC 20012 Nikki Reynolds/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Ceme. 02-20-2009 Brentwood, MD Ft. 4 Donation 5 Other (Specify) 21 Signature of Puneral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Hm 108 W. North Ave. Baltimore, Md 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lan Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de th? ፩ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To Impatient 2 ER/Outpatient 3 DOA 27. May er of Dear Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Zhatural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No after death Director: A 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. the Funeral Dirr 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 To the I 29c. License number 29b. Signature and title of certific Name and address of person wi completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mon

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a-b, per1nf 6889 3/13/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 9:30 a M Sicks February 18 2009 Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll 102 Highland Road Westminster 9. Birthplace (State or Foreign Country) Indiana If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
DEC 9 1907 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 1 □ M 2 X F 101 304-14-3079 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinating to notified a 1 Tyes 2X No **Funeral Director** Carroll Westminster MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 102 Highland Road 21157 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White Be Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Melissa Crews Jesse D. Hughes ျှ 19a Informant's Name/Relationship (Type Print)

Judy L. Lanahn — Granddaughter

Kathy Carico granddaughter

19b Maijing Address (Street and Number or Bural Route Number City or Town, State, Zip Code)

436 / Poole Road, Finksburg, MD 21048

102 Highland Road, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o once. 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Metro Crematory, Inc.02/19/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services Licenseen, H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to for as a consequence of): Hewt f c11 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ohysician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SE Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A eletely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 H53939 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Imancel, Do; 218 washington Heights Med Cfr; Westminster,

Registrar

State

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Karen S. Stover 21:00 12009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death SALTIMORE Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1953 1 □ M 2 🗓 F Months Days Maryland 55 Yrs 218**-**66-3670 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No Baltimore Halethorpe Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 5100 Chestnut Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Funk Mary Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5100 Chestnut Avenue Halethorpe, Maryland 21227 Stephen J. Stover, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 02/19/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee MacNabb Füneral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FRANY CARD A unewy disease or condition resulting in death) Due to (or as a consequence of): Hypertalemia Kn ocin Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🖼 No 2¥No 1 ☐ Yes 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

1 ☐ Yes 2 ☐ No

20553

HOSPITAL

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AGNES

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

FEBRUANY 18, 2009

BACTIMONE, MO

**Physician** /Medical Examiner Records, P.O. Box 68760,

Physician

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Experiment to mast be marked.

Baltimore, Maryland 21215-0036

/Medical

Funeral Director

Completed by

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

6 ☐ Could not be

FEB 1 9 2009

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ear) 32. Aegistrar's Signature

led by the attending physician and detached for use as the burial-transi

certificate has

After this

filled in by the funeral director,

completely

The law requires that the death certificate be executed Division of Vital Hospital or Attending Physician: 4 hours after death. within 24 hours a

To the Funeral C

> State Registrar

1

anke

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City. Town, or Location of Death

2. Date of Death

Day

	1. Decedent's Name (First, Middle, Last)
Physician /Medical	Magdalena Stefan
Examiner	4a. Facility Name (If not institution, give street and number)

Se quare 0 ran Klin If Under 24 Hrs Hours Min. If Under 1 Year **Funeral** Months Days 1 □ M 2KXF 93 Yrs 218-44-0225 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Baltimore Maryland Essex 10e. Street and Number 10f. Zip Code 21221 303 Margaret Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes XXNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. Completed by 3℃Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilhelm Blasy Maqdalena Bauer ဂ္ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Evans (Daughter) 428 Virginia Avenue, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date Department of I-Important: if ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 02/21/2009 Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of a linski Funeral Home, P.A. 21. Signature of Fune al Service Licensee 23a. Part1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of): Examiner The law requires that the death certificate be executed bunal-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760; attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 24a. Was an tage 2 s autopsy ifice te or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) direct cer Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 1 Natural (Month, Day Year) 5 ☐ Pending investigation ours after death.
neral Director: Ai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospitai within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 00000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore Md SIMON

32. Registrar's Signature

2009 tebruary 4c. County of Death Bal 9. Birthplace (State or Foreign Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 20c. Location - City or Town, State Baltimore, Maryland 1407 Old Eastern Avenue, Essex, Maryland 21221 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed 1□ Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

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			For State Registrar	State of M	arylan		artment <i>rtificate</i>			and M	iental H	-	2000	0497	C
			Decedent's Name (First, Middle)	e, Last)							2. Date of D			3. Time of Death	_
L	Physici /Medio		James Colema	n Shoemaker						ł	Month	UAPS	Pay 14 Deor	9 7.002	М
-	Examir		4a, Facility Name (If not institution	, give street and number)			4b. City, To	own, or I	Location o	of Death	0		c. County of Dea		
-45		И	BALTIMORE WA				BATTE		CL	22	KURN	C. Land	ANNE 1	AZUNDER	
	Funeral Director		5. Social Security Number 219–22–3914	1 X M 2 □ F	je <i>(In yr</i> s. 80	last birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of B	irth Da <i>y</i> , Yea	(r) Co	thplace (State or Forei ountry)	,
	ס		Usual Residence of Decedent								Aug. 1	, 19	928  Nor	th Carolina	a
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in Arcial Event are roust be notified at once.	5	10a. State 10b. County			ty, Town or Lo								10d. Inside City Limit	
	the M 28a-f	Funeral Director	Maryland Anne 2	Arundel	G1	en Bur	nie 10f. Zip C	ode.				100.0	Citizen of What Co	1 ☐ Yes 2 ☑ N	-
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Maryland	12 sh th and 7 Is m traum		19a. Informant's Name/Relationsh										or Town, State, 2	Zip Code)	
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			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each lin	the death									Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition	SEF	2515									Onset and Death	
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Box	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	Ideath 3□	Ectopic preg						23d. Date of deli Month	very Day Year	
		Physician/Med	1 □Yes 2 □No 9 □ Unknown	9 Unknown	t time of u	eath 5	JOHEL (Speci	(IIY)							
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Division of	al or Attend after death Director: / d in by the f	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At ho	me, farm, stre	et, factory, of	fice		2	8f. Location (	Street a	nd Number or Ru	ral Route Number,	
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	To the Hosp within 24 ho To the Fune completely f	Me	29b. Signature and title of certifier	and manner sta	ileg.		29c. Li	icense r	number			_29d. Da	ate signed (Month	, Day, Year)	_
h			) Sul	e15)	mi	>	5	, 4	500	49	H	200	suave	14 200 4	
	10		30. Name and address of person w	no completed cause of de	eath (Item	23a) (Type, F	Print)	٨	(O:	1	1			1 0 1 2	1
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			For State Registrar	State of Maryland /		artment of F rtificate of I		and Mental H	ygiene Reg. No. 2	009	04976
	Physici	an	1. Decedent's Name (First, Middle, Las	it)				Date of D    Month	eath Day	Year	3. Time of Death
· man	/Media	cal	CHAUNCEY HARRING 4a. Facility Name (If not institution, give			4b. City, Town, o	Logation		RY 14,	2009 nty of Death	2:15 P <sup>M</sup>
أمسور	Examin	ier	PRINCE GEORGE'S H	,		CHEVERI		i Deatti			EORGE'S
	Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 2			9. Birth	place (State or Foreign
	Director		249-34-4966 Usual Residence of Decedent	83	Yrs.			JAN. 1	2, 2009		
	aryland show		10a. State 10b. County	10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	MD PRINCE O	GEORGE'S FORE	STV	ILLE				į	1 X Yes 2 ☐ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	sath w	Funeral	3103 VICEROY AVEN	12. Was Decedent Ever in U.S.	12 1	20747		nin? (Specify Vas or N	USA	ace - Ameri	can Indian
ယ	'natural', or items 23a or 28a-f show		11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Forces?  1 XYes 2 □ No 4 / 1944 If Yes, Give	. 10.1			gin? (Specify Yes or N , Puerto Rican, etc.)	14. F	lack, White,	
21215-0036	ours a	d by	3 Widowed 4 Divorced	Year or Dates: 5/1946		1 □Yes 2 💢 No	Specify:		Spe	RT	ACK
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212	filed within Hygiene. other than '	omo	Elementary/Secondary (0-12) 9TH	College (1-4or 5+)		NG ASSIST	,		DC GEN	NERAL	HOSPITAL
	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Everthar must be notified at	Be C	17. Father's Name (First, Middle, Last)	•			18. Mothe	r's Name <i>(First, Middi</i>	e, Maiden Surn	ame)	
<u>y</u> a	should be fi and Mental h s marked ot umatic ever	ဥ	THOMAS WARREN SMO	1				HARRINGTO			
Maryland	nd 2 sh alth and 27 is n er traun		19a. Informant's Name/Relationship (7) MARY C. SMOOT / V	· · · · · · · · · · · · · · · · · · ·		VICEROY		r or Rural Route Num	iber, City or Tov /ILLE <b>,</b> N		p Code) 1747
	s 1 and f Health item 27 other t		20a. Method of Disposition	20b. Place o	of Dispo	sition (Name of natory or other place	- :	Date	20c. Locatio		<u> </u>
m 0	Pages nent of the surt: If ite		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State	-	N CEMETER		2-18-2009	BRENTV	OOD,	MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licen	DONALD R. GRAY		Name and Addre			'S FUNI		OME OF MD 0746
			23a. Part 1 Enter the disease, or compositions, or heart failure. List only	lications that caused the death. Do one cause on each line.	not ent	er the mode of dyir	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
ð	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CIRCULATORY		LAPSE					Oriset and Death
	Examiner			Due to (or as a consequence VOLUME DEPLE		NT					
		ner	Sequentially list conditions, if any, recomp to firme that cause. Enter Underlying Cause, (Disease or injury	b. VOLUME DEL LE		.v				30	
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cPSEUDOMEMBRA		S COLITIS	<b>5</b>				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit		resulting in death, East	Due to (or as a consequence	ot):						
9	ifficate g phys as the	edical		d							
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3[	Ectopic pregnanc	v			Date of deliv	
0.	at the des by the at tached fo	/sici	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 C	Other (specify)				Month	Day Year
σ.	that the		Part II. Other significant conditions of	ontributing to death but not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
Records,	w requires that s been signed t should be dete	Completed by						1	]Yes 2∑ No	3☐ Pro	bably 4 Unknown
ဝ၁	e law re has bee ie 2 sho	plet						24a. Wa	s an 24	b. Were auto	opsy findings available ompletion of cause of
		Som						per 1 □ Yes	formed?	death? 1 ☐ Yes	
of Vital	Physlcian: Th r this certificate ral director, pag	æ	25. Was case referred to medical examiner?	Hospital:		y all Doa Oth	or:	of Death (Check only			
	ding Phys h. After this funeral dii	٦: <u>۲</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Injury 28b.	Time of	28c. Injur	y at	rsing Home 5 Re	sidence 6 0	(	ffy)
jon	Attending ir death. ector: After by the fune	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Work	k? Yes 2 🗆 N	No			
Division	i die die	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	eet, factory, office		28f. Location City or To	(Street and Nui own, State)	m <i>ber or Rur</i>	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledg iner: On the basis of examination a and manner stated.	je, deatl nd/or in	n occurred at the till vestigation, in my o	me, date an pinion, dea	d place, and due to the th occurred at the time	e cause(s) and e, date and plac	manner as e, and due t	stated. to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	1.00		29c. Licens	e number	-	29d. Date sig	ned (Month,	Day, Year)
			/ h	- and car	<b>(</b> Τ	D5286	55		FEBRUAL	RY 14,	2009
+1			30. Name and address of person who of K. MICHAEL FIGARO	2001 HOSPITAT	DD	CHEVERIV	, MD	20785			
	Sta		31. Date filed (Mönfh, Day, Year) FEB 19 2009	32. Registrar's Signature	barr	W	-				
	Registr	ar	FEB 1 9 2009	parison for the	Sales o						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12, Feb. <u>Lorraine</u> M. Stansbury 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Overlea Health And Rehab Center Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2K□ F Months Days Hours Sept.28,1933 Director 213-30 8805 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lightly or other traumatic event, the Medical Evantment, and be notified an once. Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3818 Kimble Rd. 21218 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Domestic Private Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Travers ပ Ruth Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Tillman/Daughter 3818 Kimble Rd. Baltimore Md 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto.NationalCem. Feb.19, 2009 Baltimore, Md 22. Name and Address of Facility CALVIN B. SCRUGGS 1412 E. PRESTON ST. 21. Signature of Funeral Service Licensee FUNERAL HOME BALTIMORE, MARYLAND 21213 23a. Part 1. Enter the disease, or complications that cau the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Immediate Cause (Final lung distor WYONIC **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examine and n Due to (or as a consequence of) Box 68760. attending physician for use as the burial that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1. Natural 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) within 24 hours after To the Funeral Direct 4 Homicide

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 🗌 Yes 5 ☐ Residence 6 ☐ Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (*Month*, *Day*, *Year*)

2 - 16 - 2 209 Kaven Blvd, Baltimore no 21239

11:30pm

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Nes 2 No

MD

State Registra

29a. Certifier

(Check only one

29b. Signature and the of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

Medical

DHMH 17 Rev 1/2001

Loch

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 19, 2009 **Physician** Mildred Osabel Tan 12:50A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Camellia Court Parkville **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 12/10/1969 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Philippines 218-79-2453 39 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 278 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, its Medical Examiner and be purified at any injury or other traumatic event, its Medical Examiner and be purified at MD Baltimore Parkville Director 1 ☐Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Philippine Philippine 1 Camellia Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 Specify: Philippines 1 ☐ Yes 2 👿 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simplicio Osabel Cleopatra Tanglao ဂ 19a. Informant's Name/Relationship *(Type. Print)* Paul Te Tan / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Camellia Court Parkville, Marylad 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillton Serv. Corp. 2/23/2009 Towson, Marvland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þe No 3 Probably 4 Unknown 1 🗌 Yes Completed been a 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) FEB 1 9 2009

13001 S. HANOVER St. BALTOMORE MD DAVID A- VEN ECHO, MO 32. Registrar's Signature

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Bernard Thomas, Sr. *Larence* 6:30PM 14, 2009 February /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care -Dulane TOWSON Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) MD 218.28.9073 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits sa or 28a-f show t be notified at 28a-f show MD Baltim are 1 Yes 2 □ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2125 3903 thnellen USA ms 23a items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or item edical Examiner r Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. important: if item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1,4or 5+) 12th grade Nivonmental Technician Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar William Garner tanes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Rock Story Randallstown MD 21133 Clarence B. Thomas Jr. Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garnison Forest 23/09 Owings Mills, MD 21. Signature of Funeral Service License Address of Facility Valley 16 Greene Funeral SUCO iberty Road Randall stown MD 2432 22. Name and Address of Facility auch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Labetes /Medical Due to (or as a consequence of) Examiner rebra caue intally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0 Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed ement Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending § as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 NoNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sad rd #209 I, monium, MD 21093 Elmonium

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

09-01317	7
Charles '	Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

naries rayior		State of Maryland / Department of Health and Mel 1- For State Certificate of Death Registrar		eg. No. 200	9 0498
Physicia Medical Examin	ın/	1. Decedent's Name (First, Middle,Last) Charles Taylor	2. Date of Deat Month February 1	th	3. Time of Death 0715 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 6000 Bellona Avenue  Baltimore		4c. County of Death	
Funeral Director			irs Min	th(MM/DD/YYYY) 9. Bird Foreig	hplace (State or
v any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	sept.	9,1934	10d. Inside City Limits
te Maryland or 28a-f show any fied at once.	ģ	MD N/A Baltimore  10e. Street and Number 10f. Zip Code	I1	0g. Citizen of What Cour	1XXYes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	2632 E. Oliver St. 212		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces 2 No 3 Widowed 4 Divorced If Yes, Give Year  1 Yes 2 No specification of this panic O If Yes, specify Cuban, Mexical Order of the Specification of the	an, Puerto Rican, etc.)	White, etc.	can Indian, Black,
hours at natural Examin	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Giver during most of working life. DO NC		16b. Kind of Business/I	ndustry
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) 11th Grade  College (1-4 or 5+) Laborer		Cleaning	Svc.
21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be Co		ner's Name (First, Middle, M ma Alston	Maiden Surname)	
MD 212 nd 2 should b ulth and Men m 27 is marl aumatic eve	10	19a. Informant's Name/Relationship (Type, Print)  Ernestine Perry/ Friend  19b. Mailing Address (Street and No. 2632 E. Oli ver			
of Her		20a. Method of Disposition  1 XX Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Mt. Carmel Cem.	Date 2/21/09	20c. Location - City or Dundalk,	
Baltimo permit. Page Department Important: injury or ot		21. Signature of Funeral Service Licensee 22. Name and Address of Faci	Cha chan -	Harris Fu	neral Hm.
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.	cardiac or respiratory arre	more, MD est, shock, or heart	Approximate Interval Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)  a. Pulmonary Thromboemboli  Due to (or as a consequence of):			_
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
IND: is	Exam	(Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
60, tte be executed hysician and e burial - transit	dical	d. UNPENDED AMENDED			
Ox 687 eath certifica attending pl		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecto 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	pic pregnancy	23d. Date of delivery Month	Day Year
P.O. B as that the d gned by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23e. Did to	obacco use contribute to	the cause of death?
ords, F w requires is been sign should be	eted I	Hypertensive cardiovascular disease, History of cerebrovascular accident	24a. Was	an   24b. Were au	topsy findings available
Recor The law T icate has b	Completed	-	autop perfor 1 ✔ Yes	rmed? death?	completion of cause of es 2 No
Vital Reorgistian: The his certificate director, page	a	examiner? Hospital: Innation 3 FE/Outpotion 3 DOA Other,	th (Check only one)  Nursing Home 5	Residence 6 ✔ Other	Scana
ion of Virtending Physiceath.	2 :	27. Manner of Death  28a. Date of Injury  (Meeth Day Year)  28b. Time of Injury  28c. Injury at Wo		how injury occurred	. Scelle
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death. Funeral Director: After this certificate has been s setly filled in by the funeral director, page 2 should	Certification:	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building,		Street and Number or Ru	ral Route Number, City
Hospi 24 hou Funer tely fil	Medical Cer	4 Homicide determined (Specify)  29a. Certifier (Check only one)  2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death			
To the within To the comple	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo.	
		30. Name and address of person who completed cause of death (Item 23a)		February 15, 200	9
\		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 21201		
St Regist	20.0	31. Date filed (Month, Day, Year)  FER 19 2009  32. Registrar's Signature			
DHMH 17 Rev 1/20 OCME 2006	001	OCME ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#18perFH, G888, 2/24/09, WS State of Maryland/Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1eLISSA 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A INIVERSITY OF MedicalCantel 8. Date of Birth (Month, Day, Nov. 10, Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** . 1974 Min 1 □ M 2 F Months Days Hours Maryland 34 Nov. 216-86-1861 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Examination once. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore MD 1 Yes 2 No **Funeral Director** 10f. Zip Code 21223 10e. Street and Number 1839 McHenry Street Citizen of What Country? United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: Never Married 2☐ Married Maryland 21215-0036 1 □Yes 2 No White Specify. \$ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  $\overset{\text{Elementary/Secondary } (0\text{-}12)}{12}$ College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gwendolyn Teves Breidenbach James Shore ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21 Parkview Drive, Seven Valleys, PA 17360 19a. Informant's Name/Relationship (Type. Print) Gwendolyn Teves - Mother Baltimore, Place of Disposition (Name of Medical Own 10 greather place) Date 20c. Location - City or Town, State 20a. Method of Disposition Bural 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2-21-2009 Memorial Park Elkridge, MD 24 Name and Address of Facility Ambrose Funeral Homes, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pailuk disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pal, Ti Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☑ Unknown Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar MD

Ahad

Negin

31. Date filed (Month, Day, Year).

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BOLTIMORELIND

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Cert	tificate of	Death	Re	eg. No.	
Ī	<b>EL.</b>		1. Decedent's Name (First, Middle, Last	)				2. Date of Deat	h 2009	3 Time of Deale 2
	Physici /Medic		Marie E.	Ulrich				February	11 2009	10 30 PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Deat	h	4c. County of Death	
4 000			ST AGNES				IMORE		n/a	
	Funeral		5. Social Security Number 6. Se	TM 21∇1 €	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	92	115.			Sept 7,	1916 Mai	yland
	and w t		10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Manyl f sho ied a	JO.	Maryland Baltimo		0					1 □Yes 2 ☑ No
	the 1 28a- notifi	Director	Maryland Baltimo	ore	Catons	10f. Zip Code		11	Og. Citizen of What Cou	ntrv?
	3a or	Ö	707 Maiden Choice	Inno ant Of	211	2122	20			,
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S				pecify Yes or No- to Rican, etc.)	USA 14. Race - Ameri	can Indian,
(0	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No				to Rican, etc.)	Black, White,	etc.
8	raf", c	by	3 X Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	nite
2	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Decede	ent's Usual Occup	ation	rking	16b. Kind of Business/Ir	
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	during most of wor			
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E E	be fill Ital H Id oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, M	faiden Surname)	
<u>Y</u>	ould Mer narke	٩	Frederick	Muller	I		Emn			gner
Maryland 21215-0036	l 2 sh h and r Is m		19a. Informant's Name/Relationship (7)		}				City or Town, State, Zip	
	is 1 and 2 of Health a item 27 Is other trai		Gretchen E. Reed/ 20a. Method of Disposition	Daughter-in-la	w 11	.109 Powe	ers Avenu		ysville, MD	
٥	ages nt of l		1 🖫 Burial 2 ☐ Cremation 3 ☐ F	nemoval nom State		ition (Name of atory or other plac	1		20c. Location - City or T	
Baltimore,	it. Printme		4 Donation 5 Other (Specify)			k Cemete	ry   2/14	∔/09  B	altimore, M	aryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highry or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Survice During Service During Bryan W. Clary	eceny,	Le 10	emmon Fun	ssorracilly neral Hom onia Road	ne of Dul	aney Valley um, MD 2109	Inc.
			23a. Part1. Enter the disease, or compashoo, or heart feilure. List only o	ica ions that aused the death.	Do not enter	r the mode of dyin	g, such as cardia	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Fir al					FAILE		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque						
	Examilier	_	Sequentially list conditions,	0						
	夏小草	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence or):					
	al-trai	xar		Due to (or as a conseque	ence of):					
200	siciar buris	E		4						
68760,	certificate be executed riding physician and see as the burial-transit	Medical		J						
Вох	anding use a		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan					23d. Date of delive	erv
Δ.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 27 No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de		Ectopic pregnancy Other <i>(specify)</i>	<u> </u>		Month	Day Year
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Division or Vital Records, I	The law requires that the death cer the has been signed by the attendin page 2 should be detached for use	Completed by F	Part II. Other significant conditions co	ntributing to death but not result	ting in the und	derlying cause give	en in Part I.		acco use contribute to t s 2 ☐ No 3 ☐ Prot	. /
Ö	w red beer shou	lete	DIABE	TES				24a. Was an	24h More guts	/ -
8	he la e has	Ę.						autopsy perform	prior to co death?	psy findings available mpletion of cause of
ta	iffication, pe		25. Was case referred to medical				00 81( 8	1□ Yes 2	No 1 □Yes	2□No
5	/sicia	To Be	examiner?	- Hospital: 10 Inpatient 2 ☐ E	B/Outnatient	3 DOA Othe		ath Check onl o	nce 6 □Other (Specil	. ,
ō	g Phy er thi	Ë	27. Manner of Leath	28a. Date of Injury	28b. Time of	28c. Injury Work		28d. Describe ho		<i>y)</i>
<u>ö</u>	ath. rr: Aft	atio	↑ Natural 5 Pending  Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
<u> </u>	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (Str City or Town,	eet and Number or Rura	al Route Number,
	ital o irs aft ral Di lled ir	ਲੁ	9.0				<u> </u>			10
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier  (Check only one)  1 X Certifying Phy  (Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the tin estigation, in my o	ne, date and pl <i>a</i> ce pinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner as s ite and place, and due to	tated. o the cause(s)
	Nithin Vompl	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (Month,	Day, Year)
}	1 1		Dans DRI.	MEDICAL DI	DCTOR	. P.	0805		2/12/0	
,	10		30. Name and address of person who co		-		7000			
	1		KWANE NTI		HTON	AVE	BALTI	MORE	MD 212	229
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 9 2000	3. Registrar's Signati	re Again	Plane &				

PAUL CWARD

		Pleas amend #5 Pe 1_ For 1_ State	r Sellate of N	Paryland/09	epa	artment of I	Health and	<b>All Copie</b> Mental H	s Are	ie	
	_	Registrar  1. Decedent's Name (First, Middle	Last)		Cei	rtificate of	Death	2. Date of [	Reg. N	ı <sub>0.</sub> 200	9 0498 3. Time of Death
Physici /Medic		Paul C. Ward						Month FEB		) ay Ye	ar . A.
Examir		4a. Facility Name (If not institution,	-	) ALTIMORE			r Location of Dea	th LTY	4	c. County of D	eath
Funeral Director				ge (In yrs. last birth	hday) 'rs.	BALTII If Under 1 Year Months Days		S. 8. Date of B	Day, Yea	<i>r)</i>	Birthplace (State or Foreig
D		Usual Residence of Decedent						sept /	, 15	723 F1	aryland
Maryla f shov	ō	MD Baltin	nore	10c. City, Town		Mills					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the I 3a or 28a	<b>Funeral Director</b>	10e. Street and Number 3048 Hunting R:			-60	10f. Zip Code 2111	L7		10g. C	Citizen of What	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examinan must be natified at once.	by	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedeni Armed Forces 1 ∭Yes 2 ☐ If Yes, Give Year or Dates:	?  No		Was Decedent of H fYes, specify Cuba l □Yes 2∏No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or I rto Rican, etc.)	No-	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
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and 2 st and 2 st lealth an m 27 Is r		19a. Informant's Name/Relationsh Sinai Hospital	p (Type. Print)	196.	Mailin 1	W. Belve	and Number or F	enue Ba	ber, City Ltimo	or Town, State	21215
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. In mortant: If then 27 Is marked other than "natural", or my injury or other traumatic event, the Madical Examplance.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Sp	ecify)	cemetery	Dispo: ; c <i>ren</i>	sition (Name of natory or other plac	ce)	Date	20c. i	Location - City	or Town, State
Balt permit. Depart Import any inj		21. Signature of Funeral Service L RONALD S	wade Viv	ector	4	Name and Addre ate Anato ltimore,	-		Ва	1timore	Street
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S cis	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of							
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physicompletely filled in by the funeral director, page 2 should be detached for use as the L	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	e of pregnancy 2  ☐ Fetal death at time of death		Ectopic pregnance	у			23d. Date of o	delivery Day Year
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Division of I or Attending Phys after death. Director: After this d in by the funeral di	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	the I	ury 28b. Tir Inji ury - At home, farm c. (Specify)	ury		y at {? Yes 2 □ No	28d. Describe	(Street a	nd Number or	Rural Route Number,
Spital or nours afte neral Dir	al Cert	29a. Certifier 1 Certifying	Physician: To the best	of my knowledge	death	occurred at the tin	ne date and plac	City or To	0.001100/	c) and manner	an atatad
the Ho nin 24 h the Fu npletely	Medical	one)	caminer: On the basis of and manner st	ot examination and/	or inv	restigation, in my o	pinion, death occ	urred at the time	, date an	nd place, and d	ue to the cause(s)
viti Con	2	29b. Signature and title of certifier	te M·B;	B-5		29c. License	- 000			ate signed (Mo	nth, Day, Year) QS
		30. Name and address of person w	no completed cause of c	death (Item 23a) (Ty	ype, F	Print)	OF 1	3A-TIMO	0=		
Stat Registra	e	SHISHIR 03 31. Date filed (Month, Day, Year) FEB 1920	32. Registr	ar's Signature	av	est 1 ML	OF /	>1-1111C	NE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day\_ **Physician** FEERTHARY 2009 9:10 FM Isamore Henderson Walker /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Haltimore 4b. City, Town, or Location of Death **Examiner** Center OWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 27, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Days 1□ M 2\ F Hours untry) MD 215-24-5709 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitive countries any injury or other traumatic event, the Medical Exercitive countries and once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2024 West North Avenue USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2K No <u>ک</u> Specify. SpecifyAfrican-American 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Social Security Admin. 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Kercy Custus Sussie Henderson 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brent S. Booker / Nephew 43774 Carrleigh Court Ashburn, Va 20147 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/2009 Metro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. ture of Funeral Service Licensee 9200 Liberty Road Randallstown, Maryland 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events. Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1∐Yes 2⊠No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC RENAL INSUFFICIENCY 24a. Was an autopsy perform 2 X No 1 □Yes 2 □No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, 🦝 attending p for use as signed by the a should ! certificate has triector, page 2 sl After this ours after death.

neral Director: Affilled in by the fur within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(M, D.

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DØØ17695

29d. Date signed (Month, Day, Year) February 15, 2009

and manner stated.

LAH M. D. 7621 OSLER DRIVE. TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar FFR 19 2009

29b. Signature and title of certifier

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WRIGHT 0824AM E. 2009 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND UNIVERSITY BALTIMORE N OF 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Days Hours 220-80-059 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Invalcal Examinating and Injury or other traumatic event, it is Invalcal Examinating and Injury or other traumatic event, it is Invalcal. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 Yes 2 No nia. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IVIS 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ater 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother nara 20b. Place of Disposition (Name of gemetery, crematory or other 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen, ee 270 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □ Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1XYes 2 □ No 1 🔲 Inpatient ≥ ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-14-09

State

31. Date filed (Month. Day, Year)

Kenneth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Butler

32. Poistrar's Signature

Registrar

Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AM Michael Andrew Wagner 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL Of BAHimora If Under 24 Hrs. 8. Date of Birth Mours Min. 09/19/1935 5. Social Security Number If Under Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days XXX M 2 □ F 73<sup>Yrs.</sup> 219-32-5341 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Middle River 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3932 New Section Road 21220 12. Was Decedent Ever in U.S. Armed Forces? XXIYes 2 \( \text{No} \) 1955-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 X No ivorced 1957 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Sheet Metal Mechanic Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Andrew Wagner Elizabeth Weidel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Wagner (Daughter) 3932 New Section Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 02/17/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Eur r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme line Cause (Final dise se or condition result on in death) Due to (or as a consequence of): sequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a co resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 □ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending 2 Accident investigation 1 Tes 2 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, aftending physician the as the been signed by the certificate funeral director, After this after death

Examiner Physician/Medical <u>Ş</u> Completed Be Certification: To 24 hours a Medical

Physician

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If w Madical Expriner must be refitted at any pines.

Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore.

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State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

UNI 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

An1

Régistrar's Signature

21

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) February 13, 2009

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State of Maryland / Departmen	t of Health and	Mental Hy	giene <	UL

			State Registrar	ate of Mai	ylulla / Dop	Juitine	nt of Heate of De	antin and n	F	Reg. No.		
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Frankie Wi	lson					2. Date of Dea Month Februar	Day Y	3. Time of Death 1:30 PM	
	Examir		4a. Facility Name (If not institution, give stree 1109 Quantril Way	t and number)			y, Town, or Lo altimo:	cation of Death		4c. County of	Death	
	Funeral Director		5. Social Security Number 6. Sex 1		(In yrs. last birthda 87 Yrs.	Months   Days   Hours   Min.   (Month, Day Year)   Country						
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	Location	<u> </u>	_			10d. Inside City Limits	
	e Mary la-f sh	ctor	Maryland		Baltimore	e					1  Yes 2□No	
	3a or 28	al Dire	10e. Street and Number 1109 Quantril Way			10f. 2	Zip Code 212	205		10g. Citizen of Wha	at Country? USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evantics must be notified at once.	by Funeral Director	1 Never Married 2 Married	Vas Decedent Ev Armed Forces? ☐Yes 2 X No fYes, Give /ear or Dates:	ver in U.S. 13			anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
215-0036	in 72 ho "natur	Completed	15. Decedent's Educatio (Specify only highest grade co	mpleted)	(Giv	cedent's Usive kind of v	sual Occupation vork done duri use retired)	on ing most of work	king	16b. Kind of Busin	ness/Industry	
212	d with giene. er thau	Com	Elementary/Secondary (0-12)	College (1-4or 5+	)	Home.	maker			Own Hon	ne	
Maryland	be file ntal H) ed oth event	Be	17. Father's Name (First, Middle, Last)	_			18			Maiden Surname)		
ıryk	should nd Me mark imatic	ဥ	John Hobson  19a. Informant's Name/Relationship (Type. I		19b. Ma	iling Addre	ess (Street and	Visty Number or Ru		ung er, City or Town, Sta	ate, Zip Code)	
, Ma	and 2 sealth ar		Betty Lee Otto (dau					Road Mi	iddle Ri	ver Mary	land 21220	
Baltimore,	Pages 1 nent of He int: If iten		20a, Method of Disposition  1   Burial 2 □ Cremation 3 □ Remode 4 □ Donation 5 □ Other (Specify)	oval from State	20b. Place of Dis cemetery, cr Cedar Hi	_		I I	Date 0/2009	20c. Location - Cit Brooklyn	ty or Town, State  Maryland	
Balti	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee	人						i Funeral ssex Mary	l Home PA yland 21221	
	Physician /Medical Examiner		23a, Part 1 Enter the disease, or complication shock or heart failure. List only one call immediate Cause (Final disease of condition resulting in death)	SQUAR	the death. Do not e					rest,	Approximate Interval Between Onset and Death	
68760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	``	consequence of):							
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total states.	Physician/Medi	in the past 12 months?	c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify)  9 □ Unknown						23d. Date of Month		
rds, P.	juires that the de n signed by the a lid be detached t	by	Part II. Other significant conditions contrib	uting to death but	t not resulting in the	underlying	g cause given i	in Part I.			ute to the cause of death?	
of Vital Records,	siclan: The law requir s certificate has been s irector, page 2 should	Completed							24a. Was a autop perfor 1 ∐Yes	rmed2, dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 □ No	
Vita	ysiclan: The iis certificate hidirector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes No	ital:		i 0 🗆	Others		th (Check only or	ne) lence 6 □Other	10 "	
on of	ding Phys h. After this funeral dir	tion: To		8a. Date of Injury (Month, Day,	nt 2 ER/Outpat y 28b. Time Year) Injun	of	28c. Injury a Work?	4 LI Nursing H		now injury occurred	(Ѕреспу)	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	a Could not be	8e. Place of Injur building, etc.	ry - At home, farm, (Specify)	street, fact			28f. Location (S City or Tow		or Rural Route Number,	
	e Hospit 124 hour e Funera letely fille	Medical (	29a. Certifier 1 CertifyIng Physicia (Check only one) 2 Medical Examiner:		examination and/or							
	To the within To the Compl	Me	29b. Signature and title of certifier	011			29c. License n			29d. Date signed (/		
	, [		· Wellon P.	In A	une A	63	016	801		18 FE13	2009	
	Sta Regist		30. Name and address of person who complete the filed (Month, Day, Year)	eted cause of de	r's Signature	e, Print) 3 F	Frankl	in Sq	. Drive	Ballimo	2009 12 MD Z1237	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Ruth Marie Walsh 2009 5:28 а м 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 8, Months Days 1 □ M 2 🛣 F Hours Min 160-20-9106 86 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√ No Baltimore Timonium Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 168 Cinder Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: SpecifyWhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foriegn Social Security Claims Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daugherty Dennis Nettie Keigh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 168 Cinder Rd. Timonium, Md. 21093 Mr. Jefferson Walsh/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-20-09 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses หักรู้ ที่ชี่พริฮ์ ห็<sup>aci</sup> Puneral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, of shock, or heart failure. Lis r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TONITI weeks Du to (or as a consequence of): MAS ROMOTIC Sequentially list conditions, if any, leading to firm ordinate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consectuance of) TUMOR CECAL - ADENOCARCINOMO Due to (or as a consequence of) yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 1 ☐Yes 2 ☐ No 1 ☐Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Apther (Specify) NOSPIL 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant with the protection once.

Baltimore, Maryland 21215-0036

burial-transi ed by the attending physician detached for use as the buria signed by page 2 should be has been certificate director, this within 24 hours after death.

To the Funeral Director: After of completely filled in by the funeral

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760,

Examiner Physician/Medical 2 Completed Be Certification: To

IF FEMALE:	
23b. Was decedent pregnant	
in the past 12 months? 1 □ Yes 2 ☑ No	
9 ☐ Unknown	
3 L CHAIOWI	

examiner?	2	medici	2
27. Manner of	-/-		

29a. Certifier

1 Natural 2 ☐ Accident 5 ☐ Pending investigation

6 ☐ Could not be 3 Suicide determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) CHANCES

(Month, Day, Year) FEB 1 9

32. Begistrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Wise Otis 12. 6:26P M Ebruan 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 3515 Spaulding Avenue Ba Itimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 50 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funerat Days Months 1**X**M 2□ F Hours 220:14:0096 Director 0403 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar rount to maitfied at Baltimore MD Director 1 XYes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? spaulding Avenue 21215 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Myes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shoreman Waterfront 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) tonie May James ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine B. Tillett 3515 Spaulding Allnue Baltimore MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 02/20/09 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vougno C Specific Funcial SIS ohn C. Mr Road Randalutown MD 21133 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) MON /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-t Due to (or as a consequence of) 68760 physician Physician/Medical as the the attending Box ( IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) □Yes 2□No 9 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ZNo director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*Locatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 Nost Belvedore

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Fe month **Physician** Williams Agnes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Year) Feb. 20, 1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Country) Months Hours 1 □ M 2 1 F 83 MD 217-12-7348 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machael Examinal natal by pathled at 1 ☐ Yes 2 No Director MDAnne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21061 514 Wellham Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Inspector Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Lorenz Tillie Augustiniak ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Charlotte Hall/Daughter 7806 Grandison Way Severn, Maryland 21144 Date 21, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb Department of Important: If it any Injury or o one. 1 Burial 2 Cremation 3 Removal from State 2009 Glen Burnie, MD Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee 20 Services PA, 1 2ndAve. SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine that the death certificate be executed for use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) detached 9 Unknown Ö 9 Unknown this certificate has been signed by al director, page 2 should be detact σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, The law requires Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an autopsy performed? Yes 2 No ∜ital ∣ 1 □Yes ospital or Attending Physician: Ti hours after death. uneral Director: After this certificate ly filled in by the funeral director, pa Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No inpatient 2 ER/Outpatient 3 DOA Certification: To ð 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division **◆** □ Natural 5 ☐ Pending investigation 2 ∏No 1 Tyes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OB V 31. Date filed (Month, Day, Year). 32. Registrar's Signature State

Registrar

EED 1 0 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** LEE **FEBRUARY** 2009 ROGER WARD 2226 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Min Director <u>578-54-9</u>992 67 DC DEC. 13, 1941 Usuai Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No PRINCE GEORGE'S FT. WASHINGTON MD10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number ò 23a Funeral 20744 7205 LOCH COURT USA Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Item Me Elementary/Secondary (0-12) College (1-4or 5+) GENERAL FOREMAN 8TH WASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT SYLVESTER WARD VIRGINIA BELL ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULETTE M. WARD / WIFE 7205 LOCH COURT FT. WASHINGTON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 02-19-2009 SUITLAND, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD SUITLAND, MD DONALD R. GRAY 4308 SUITLAND ROAD 20746 23a. Part. Enter the disease, or shock, or heert failure. List plications that caused the death. one cause on each line. Approximate Interval Between Onset and Death To not enter the mode of dying, such as cardiac or respiratory arrest. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy 1 ☐ Yes 1 ☐Yes 2 ☐ No 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 124 hours after death.

• Funeral Director: After this cletely filled in by the funeral dire 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the companies. 29a. Certifier Medical

of Vital Records, Hospital or Attending Physician: Division within 24 hou

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Baltimore, Maryland 21215-0036

Box 68760,

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State Registrar

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29b. Signature a

30. Name and address of person who co

31. Date filed (Month, Day,



death (Item 23a) (Type, Print)

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On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amedn #26 per MD 9888 2/19/09 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Charles 5:50 PM Walton Feb.13,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frankford Nursing Home Baltimore n/a If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□ 229 18 3190 87 Director July 10,1921 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD n/a Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 3104 E. Federal St. 21212 23a USA death v Funeral items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. filed within 72 hours after of Hygiene. ☐Yes 2☐No f Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√2 No Specify If Yes, Give Year or Dates: Specify: black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th is marked other than College (1-4or 5+) Inspector Railroad other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance and Mental F ss 1 and 2 should be of Health and Mental Item 27 is marked ပ္ Charlie Walton Lucy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sweetie Walton (wife) 3104 E. Federal St. Baltimore, Md. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills Cem Feb. 20, 2009 Balto. Co, Md. 21. Sign Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 23a. Part1. Enter the disease, or complications that caused the depth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death noctate Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (un as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for 1 in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No ed by the a 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an has certificate 1∏ Yes 2 No Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3□ DOA 1 Tyes r 1 🔲 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Attending Injury 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date sigged (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Walkenn Words lad 8813 31. Date filed (Month, Day, Year) Registrar's Signatere State FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1/30/2009 CATHERINE LEE ALLEN 10:45 a M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE"S FUTURECARE PINEVIEW CLINTON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Director 81 250-28-7242 12/4/1927 Timmonsville, SC Usual Residence of Decedent r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ritems 23a or 2 liner must be n 4805 Newman Rd. 20746 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married ral", or i Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> Specify: Black 3 ₩idowed 4 Divorced natural Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o David Friday Carrie Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Carrie Dawson / Daughter 4880 Cranston Ct. Waldorf, Maryland 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Harmony Memorial 2/4/2009 Landover, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. 23a. Part1. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ♣No Month Day Year 5 Other (specify) P.O. signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of has death? 1 ☐ Yes 2 □ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After or Attending Injury 1 Natural within 24 hours after death.

To the Funeral Director; Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29b. Signature and title of certifier

(Check only one)

and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 0 3 2009

of person who completed cause of death (Item 23a) (Type, Print)

HOSDHAI -32. Registrar's Signature

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LIHIE

29c. License number

29d. Date signed (Month, Day, Year)

01-30-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2009 Catherine Allen 15 am Muary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctor's Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🖺 F Months Days Hours Min. 143-18-2749 90 Director Jan 2, 1919 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ihw Medical Examiner must be norther anong. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Bowie 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13308 Yorktowne Drive 20715 United States Funeral 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Examiner 12 years Currency Examiner 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Clifton Moody, Sr. Fannie Green 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Parker - Daughter 17211 Russet Drive Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Feb 7, 2009 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MAUGNANT Immediate Cause (Final Onset and Death **Physician** CARDIAC disease or condition resulting in death) /Medical **Examiner** MONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal-transmit DEMENTIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mo Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 1 ☐ Yes 2 ☐ No 2 C M 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 2 🗆 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State Registrar

29b. Signature and title of certification

31. Date filed (Month, Day, Year)

FFR 0.3 2009

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

reorae

DHMH 17 Rev 1/2001

OD HONOVER

29d. Date signed (Month, Day, Year) January 31 2009

Parkway Suite 1019 Greenbelt, MO 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar AMEND#23a-IIpe		land / Depa	artment of	Health and	Mental Hyg	iene <sub>19. No.</sub> 2 0 0 9	9 04996
	Physic /Medi	cal	David Je      David Je      As Fecility Name (If not institution, give	remiah	Austin	4h City Town	or Location of Deat		8 , 2009 Year	
	Exami	ner	Holy Cross Hos	pital		Silve	er Sprin	g	Montgo	omery
	Funeral Director		5. Social Security Number 6. Security Number 10 10 10 10 10 10 10 10 10 10 10 10 10	TM 2□F	yrs. last birthday) Yrs.	Months Bay		8. Date of Birth	2009 M	irthplace (State or Foreign Country) aryland
	te Maryland Ba-f ehow	ctor	MD 10b. County Prince	George's	Beltsv					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	h with th	al Dire	10e. Street and Number 3802 Calverton	Blvd. #36	6	10f. Zip Code 20	705	10	og. Citizen of What (	Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiane. Item 27 Is marked other then "neturel", or iteme 23a or 28a-f show other treumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of i Yes, specify Cu I ☐ Yes 2 AN	Hispanic Origin? (S ban, Mexican, Puerl o <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Black
Maryland 21215-0036	within 72 ho lane. 'then *netur 'the Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occi kind of work done OO NOT use retir	upation e during most of wor red)	king	16b. Kind of Busines	,
yland 2	should be filed vind Mental Hygia marked other timmatic event, III	To Be C	17. Father's Name (First, Middle, Last) David Austin				Kym T	ne (First, Middle, N hompson		
	1 and 2 sho Heelth and Iem 27 Is my other treums		19a. Informant's Name/Relationship (Ty, Kym Thompson/M	other	380	2 Calve	erton Bl	vd.#36	City or Town, State, Beltsvil	. <i>Zip Code)</i> .le <b>,</b> Md20705
Baltimore,	permit. Pages 1 Department of H Importent: If iter eny injury or oth		20a. Method of Disposition  1	Sillovar ilolli State	b. Place of Dispos cometery, cren Gate o				Silver S	or Town, State Spring, Md
Bal	Departimon Imported in Sun Sun Sun Sun Sun Sun Sun Sun Sun Su		21. Signature of Juneral Service License	uld'	P 9	HTLTPAdq 241 Col	אלינית Sintal Dia B Sintal B	I FUNER	AL SERVI ver Spri	CE,P.A. ng,Md20910
	Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Respirat Due to (or as a con Pneumoth Due to (or as a con	sequence of): noraces sequence of):	ilure	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death 2days
8760,	ate be executed thysicien and the burial-transit	Ilcal Examiner	that initiated events resulting in death) Last	Pulmonar Due to (or as a con Prematur	sequence of):		birth w	eight		8days 8days
P.O. Box 68	The law requires that the death certificate to the law requires the latending physicage 2 should be detached for use as the tops.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	oc. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date of de Month	elivery Day Year
Records, P	w requires that been signed b should be deta	ò	Part II. Other significant conditions con Pulmonary hype: Symmetric Intraut	rtension, erine Growth I	resulting in the un pulmonary PTE,	derlying cause of	Yal Palphyse	ma 23e. Did toba		to the cause of death? Probably 4 □Unknown
al Rec		Completed	Symmetric IUGR	possible				24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of s
Ţ	Physician: this cartifica al director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:	2 ☐ ER/Outpatient	3 DOA O	h	th Check only one ome 5 ☐ Residen	ce 6 □Other (Spe	acifu)
Division of Vital	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this cartific completely filled in by the funeral director,		27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b Time of	28c. Inju		28d. Describe how		
Divis	in Signal	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		281. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	To the Hospital within 24 hours a To the Funeral t completely filled	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	cian: To the best of my lar: On the basis of exam and manner stated.	knowledge, death ination and/or invi	occurred at the ti estigation, in my	ime, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	withi To th	×	29b. Signature and title of certifier	www.r	nD	29c. Licen:	se number	290	d. Date signed (Mon	th, Day, Year)
	Ì		30. Name and address of person who con Sharon C.Kierr			rint)		ilver Sr	oring,Md	20910
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 4 2009	32. Registrar's Sig	gnature San			TTVCI D	z z my j mu	207:0

DHMH 17 Rev 1/2001

09-00935 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Thiago Andrade 04997 2009 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ S. Andrade Thiago 1238 hrs Medical Examiner February 1, 2009 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville Viers Mill Rd. @ Robindale Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days oreign 048-88-9435 Hours Director Country) 1 X M 2 17 Yrs Dec. 5, 1991 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a State 10b County Yes 2 X No s 23a or 28a-f show e notified at once 28a-f show Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 13808 Congress Drive 20853 USA the Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status must be or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 X Never Married 2 x No Yes White Yes 2XX No specify: after Widowed Divorced If Yes, Give Year Specify: event, the Medical Examiner "natural" à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72
nent of Health and Mental Hygiene. marked other than 10 Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Andrade Marcilene Silveira Mendonca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Marcio A. Figueiredo/Step-father 37 Neds Mountain Road, Ridgefield, CT 06877 Baltimore, Permit, Pages 1 and Department of Heal 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition (ant: If it crematory or other place) 1 X Burial 2 Cremation 3xx Removal from State Feb. Danbury, CT Wooster Cemetery Donation 5 Other Specify: 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. Collins Funeral Home versity Blvd., W, Silver Francis 500 Uni Spring, MD 20901 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause, Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED ending physician use as the burial AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q Unknown signed by the detacher P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, page 2 should peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? Yes Yes 2 1 🗸 No director, 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be examiner? Other 4 Hospital: DOA Nursing Home 5 Residence 6 V Other: Scene FR/Outpatient 3 Inpatient 2 this ို 1 ✔ Yes No funeral 28a. Date of Injury After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Feb 1, 2009 Passenger auto fixed object collision 1238 hrs Natural hours after death. 1 Yes 2 ✔ No Pending filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Viers Mill Road @ Robindale Road, Rockville, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

OCME 2006

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signatu

my. 30. Name and address of person who completed cause of death (Item 23a) 29d. Date signed (Month, Day, Year)

February 2, 2009

Ling Li, MD

31. Date filed (M4

State

29b. Signature and title of certifier

29c. License number

O.C.M.E.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		•	For State Of War	Cer	tificate of D		R	leg. No.	200	-01-000	
	Physici:		Decedent's Name (First, Middle, Last)     HELEN BOYLICS ARKEY				2. Date of Dea Month FEB. 1,	Day	J Vear	3. Time of Death O	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) CHESTERTOWN NURSING & REHAB		4b. City, Town, or Location of Death CHESTERTOWN				4c. County of Death		
I	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2X F 7. Age 1 ☐ M 2X F	(In yrs. last birthday) 93	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 8/23/1	; Year)	9, Birthp Cour	place (State or Foreign stry) PA	
e, Marylan	Maryland a-f show	ctor	Usual Residence of Decedent						1	0d. Inside City Limits 1   Yes 2   No	
	h with the 23a or 28a	al Director	10e. Street and Number 408 MORGNEC RD.		10f. Zip Code 21620			10g. Citizen of What Country? USA			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Examed Forces?  1 □ Yes ② No If Yes, Give Year or Dates:		<ul> <li>13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> <li>1 □ Yes 2 XNo Specify:</li> </ul>			14. Race - American Indian, Black, White, etc.  Specify: WHITE			
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give life, L	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  CLERICAL				o. Kind of Business/Industry		
		To Be Co	17. Father's Name (First, Middle, Last)  JOHN BOYLICS	, OBB				Middle, Maiden Surname)			
			19a. Informant's Name/Relationship (Type. Print)  LEE MYERS/GRANDDAUGHTER	-1	19b. Mailing Address (Street and Number or Run 11566 POSSUM HOLLOW RI			al Route Number, City or Town, State, Zip Code)			
			20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place		Date	20c. Location			
Balt			21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620								
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed to the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director.	Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or light what initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
			IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   1   1   1   1   1   1   1   1   1					23d. Date of delivery Month Day Year			
		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
		Certification: To Be Completed							mpletion of cause of		
			examiner?					esidence 6 Other (Specify)  be how injury occurred  1 (Street and Number or Rural Route Number, Town, State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	To the within 2 To the I complet	Medical	29b. Signature and title of certifier	<u>.                                    </u>	29c. License number			29d. Date signed (Month, Day, Year) 2/2/09			
<b>,</b>	1		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Washing	Print) ton Ave.	, Ches	tertown			20	
	Sta Regist		31. Date filed (Month, Day, Year)	r's Signature	6.41						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 21 2009 **Physician** January 7:11 AM Lucille Anderson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Jan 17 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup>920 Days 1 □ M 2√2 F Months Hours Maryland 578-18-3016 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Medical Examination unit be putified an once. 1 □Yes 2 😾 No Director Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 999 Christmas Lane 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. þ Specify: 3√ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) 12th Crossing Guard Police Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Joseph E. Parker Ellen Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Anderson(Daughter) 2013 Cambridge Dr. Crofton, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran | 1-29-09 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Winhame Reverse of Scilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia for respiratory arrest, shock, or heart failure. List only one cause of each line. 1020483 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Clemil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and a parts. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Month Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed 2 40 certificate 2 ANG 1 ☐ Yes 1 ☐ Yes . Hospital or Attending Physician: 24 hours after death.
2 hours after death.
5 Funeral Director: After this certifica etely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

State

29a. Certifier

(Check only one)

31. Date filed (Monti

29b. Signature and title of certifie

Registrar DHMH 17 Rev 1/2001 of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Year 9 2. Date of Death 3. Time of Death Day Month JANUARY 30, 200 Alton Luther Allen, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NISTA CENTER MEDICAL If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 **¼**M 2□ F 217-28-1819 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Y☐Yes 2☐No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20640 U.S.A. 2 Evelyn Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Xes 2 □ No If Yes, Give Year or Dates: 1 1 Never Married 2 Married 1951-<sup>1953 1□Yes</sup> 2√2No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Auto Body Mechanic Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde Allen, Sr. Viola Kramer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 2 Evelyn Lane, Indian Head, Md. 20640 Margaret Allen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3, 2009 Indian Head, Maryland Charles Cemetery 22 Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service License M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter in dis shock, or h ≠ rt fal Immediate Cause († nal disease or condition resulting in death) Approximate Interval Between Onset and Death ase, or complications that ure. List only one cause on ear d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, CESPIRATORY HRRES MONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EVERF 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner The law requires that the death certificate be executed burial-trans physician the buria Box 68760 as I o ۵. of Vital Records,

Division

After this certific funeral director, ne Hospital or Attending Pin 24 hours after death.

Permeral Director: After the Funeral Director of the funeral pletely filled in by the funeral

Physician

/Medical

**Examiner** 

**Funeral** 

**Director** 

an "natural", or items 23a or 28a-f show Medical Exactiver must be notified at

21218

Maryland

Baltimore,

Pages 1 and 2 should be

Department of Heal Important: If item 2 any Injury or other once.

**Physician** 

Director

Completed by Funeral

Be

Physician/Medical <u>ک</u> Completed Be Certification: To

Medical

Examiner

25. Was case referred to medical examiner? 1 Yes 2 No

> Natural 2 ☐ Accident 6 Could not be determined 3 Suicide

4 Momicide 29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check on one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONG C. CHON MD 31. Date filed (Month, Day, Year) FEB 0 4 2009

CENNA MEDICAL 32. Registrar's Signature

WALDORF 20602

Registrar